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AUTHOR Strautin, Astra Lydia
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ABSTRACT

Today's society, in large part, has granted public acknowledgment of the practice of homosexuality as an "alternative lifestyle" and as a valid expression of sexuality and self. However, there are men and women who, having engaged in an active homosexual lifestyle for varying lengths of time, feel regretful about their homosexuality and want to alter their orientation. The study of homosexuality has engendered considerable dialogue and controversy about its etiology, with recent studies attempting to determine factors that might indicate a genetic and/or hormonal basis. The results have provided evidence to suggest that some individuals are biologically predisposed to experience feelings or exhibit behaviors consistent with a homosexual orientation. Developmental, familial, and societal factors appear to contribute to the emergence of homosexuality as well, although theorists and researchers have yet to supply conclusive data to indicate which of these factors, and to what degree, influence the formation of one's sexual identity. No research data have been found to support etiological differences between male and female homosexuality, although theories suggest that disruption of the relationship with the same-sex parent may have occurred. The most effective treatment for those wishing to change their orientation appears to utilize both group and individual therapies, although some recurrence of homosexual feelings and behaviors seems likely. Further study is required to determine factors affecting maintenance of change and continued progress following treatment. (LLL)

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MALE AND FEMALE HOMOSEXUALITY: A REVIEW OF DIFFERENTIAL
FACTORS IN ETIOLOGY AND IMPLICATIONS FOR TREATMENT

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology
Biola University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Psychology

by

Astra Lydia Strautin

May 1992

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by

Astra Lydia Strautin

APPROVED:

Sarg H. Strass, Ch. R. Date 5/8/92
First Reader

William R. Hunter, Ph.D. Date 5/8/92
Second Reader

APPROVED:

Eric J. Howard, PhD
Dean

5/8/92
Date

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ABSTRACT

MALE AND FEMALE HOMOSEXUALITY: A REVIEW OF DIFFERENTIAL FACTORS IN ETIOLOGY AND IMPLICATIONS FOR TREATMENT

by

Astra Lydia Strautin

The literature discussing the etiology and differential factors in the development of male and female homosexuality is reviewed. Perspectives regarding treatment issues with ego-dystonic homosexuals are presented. Studies have determined that biological factors may predispose some individuals toward homosexuality, but a combination of social, familial, and emotional factors appears to influence the likelihood that a homosexual orientation becomes manifest. No research data have been found to support etiological differences between male and female homosexuality, although theories suggest that disruption of the relationship with the same-sex parent may have occurred. The most effective treatment for those wishing to change their orientation appears to utilize both group and individual therapies, although some recurrence of homosexual feelings and behaviors seems likely. Further study is required to determine factors affecting maintenance of change and continued progress following treatment.

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Thank you, Lord, for your faithfulness and mercies, which have been new every morning in recent months. Use this work to glorify your Name and to provide insight and hope for those who are in need.

"Since I know, O my God, that Thou triest the heart
and delightest in uprightness, I, in integrity
of my heart willingly offer all these things."
I Chronicles 29:17

"It is good to give thanks to the Lord,
and to sing praises to Thy name, O Most High,
to declare Thy lovingkindness in the morning,
and Thy faithfulness by night."
Psalm 92:1,2

Male and Female Homosexuality: A Review of Differential Factors in Etiology and Implications for Treatment

Introduction

Our present society, in large part, has granted public acknowledgment of the practice of homosexuality as an "alternative lifestyle" and a valid expression of sexuality and self. However, there are men and women who, having engaged in an active homosexual lifestyle for varying lengths of time, feel regretful about their homosexuality and want to alter their orientation. Bell and Weinberg's (1978) study indicated that approximately 18% of gay men and 8% of lesbians would be considered "dysfunctional" due to their regret and level of distress. In spite of such data, most individuals with a same-sex sexual orientation have not been given a great deal of hope for fundamental change of orientation.

Within the homosexual community, many suggest that the distress of such individuals stems from "internalized homophobia," which generates anxiety when feelings of attraction arise for someone of the same gender. Proponents of this view attribute perpetuation of such feelings to the general culture's "homophobic attitudes" toward the gay community. Some consider any psychotherapist willing to

work toward change of sexual orientation as unethical in practice (Davison, 1976; Sobocinski, 1990). Instead, for clients questioning and judging unwanted feelings of homosexual attraction and identity, some therapists work toward the incorporation of such feelings through increased self-acceptance of the client's homosexual identity and reduction in intensity of internalized homophobia (Acosta, 1975; Smith, 1980; Sophie, 1987). Such an approach in therapy is often based on the assumption that a client's refusal of his or her gay identity and the decision to leave the gay lifestyle are not motivated by legitimate resolve, personal values, or rational thought, but, rather, out of guilt and shame driven by societal rejection (Davison, 1976). The result, however, is that the struggling client feels more misunderstood, discouraged and isolated than before, with little hope of escaping compulsive, and sometimes destructive, behavior patterns (Nicolosi, 1991).

The opinions regarding the usefulness of treatment of homosexuality are based on reported success rates with ego-dystonic homosexuals in various psychotherapeutic settings utilizing various treatment modalities. Some therapists have attested to major reorientation of sexual identity in 19% to 50% of their clients (Bieber, Dain, Dince, Drellich, Grand, Gundlach, Kremer, Rifkin, Wilbur, & Bieber, 1962; Mayerson & Lief, 1965). Others consider such claims to be exaggerated and erroneous.

Tripp (1975), one such skeptic, stated that "no known 'cures' for homosexuality" (p. 251) have been documented in empirically-based studies, and that reports of success are based on unsubstantiated secondary sources. To this critique of the Bieber et al. (1962) claim, Tripp added that only one person responded to the Kinsey Research Center's invitation to evaluate anyone who claimed to have changed his/her sexual orientation, and only one person in the Kinsey program was identified as having changed (Blair, 1978). Churchill (1967) disputed the Bieber et al. study as well, stating that the study's sample was not representative of the homosexual population, thereby questioning the applicability of Bieber's conclusions to members of the larger gay community.

Because there are conflicting reports of the possibility of viable change in the homosexual's sexual orientation, it is important to determine the major factors that have potential impact on the development of homosexuality in both males and females. A review of these factors and reasons for contradictory opinions follows. Whether the information has been, or still needs to be, applied differentially to men and women in therapeutic settings is examined briefly, as is the most effective manner of applying theory to treatment. Previous research is examined in order to (a) determine what factors are crucial in obtaining positive outcomes from treatment, and

(b) evaluate the appropriateness and efficacy of treatment of those with a homosexual orientation.

The intent of the reviewer is to understand the unique needs of the individual struggling with ego-dystonic homosexual feelings, and to assess the level of assistance that can be provided through therapy for those who wish to change their sexual orientation. Much of the literature indicates that homosexuals benefit from therapy only to the degree it teaches them to cope with their orientation more effectively and to accept their fate. However, there is also a literature which offers hope for substantive change in sexual identity and orientation.

Contradictory information regarding treatment outcome may be a reflection of inadequate theoretical conceptualization and application, as well as personal biases in favor of or against homosexuality. Therefore, the importance of a sound conceptual basis is crucial if psychotherapy is to be used to facilitate positive, lasting change for the ego-dystonic homosexual.

Definitions

Homosexuality is a confusing term to define and even more difficult to identify in individuals. The question that needs to be answered is who is a homosexual, and by what criteria is one considered a homosexual. In the Oxford American Dictionary (1980), a homosexual is defined as an

individual who "feels sexually attracted only to people of the same sex" as himself/herself (p. 313). This definition encompasses intrapsychic phenomena of attraction as part of the person's sexual desire, but may allow for its behavioral manifestations as well. Marmor (1980), realizing the distinction between attraction and behavior, defined a homosexual person as "one who is motivated in adult life by a definite preferential erotic attraction to members of the same sex and who usually (but not necessarily) engages in overt sexual relations with them" (p. 5).

From a psychiatric perspective, the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-III, 1980) distinguished two types of homosexuality: ego-syntonic and ego-dystonic, the latter classified as a psychosexual disorder. Homosexuality had been categorized as a psychiatric disorder in prior editions of the Manual. The change in DSM-III to listing of ego-dystonic homosexuality only was the result of political lobbying and a much publicized vote in 1974 by the American Psychiatric Association (Jones & Workman, 1989). Following additional debate, the revised edition, DSM-III-R (1987) currently in use did not list ego-dystonic homosexuality as a distinct disorder, but incorporated it as "Sexual Disorder Not Otherwise Specified" (302.90). Appendix D of DSM-III-R explains that "an example of Sexual Disorder NOS are cases

that in DSM-III would have met the criteria for Ego-dystonic Homosexuality" (p. 426).

Klein (1981) has developed an instrument based on the view that sexual orientation is multi-faceted, rather than dichotomous. The more commonly used measure, the Kinsey Scale, was based on the view that sexuality can be categorized primarily on the exclusive heterosexuality-exclusive homosexuality continuum, with a focus on the aspect of sexual behavior. Klein (1981) introduced the Klein Sexual Orientation Grid (KSOG), which expanded Kinsey's conceptualization by adding the variables of (a) self-description as a sexual being, including fantasy life, attraction, and behavior; (b) aspects of sexual orientation, including emotional and social preference, and lifestyle; and (c) self-identification as a homosexual. Anderson-Barnes (1990/1991) incorporated sexual dreams as an eighth variable. The KSOG not only provides a more comprehensive assessment of sexual orientation, but suggests that change in one area of functioning, e.g., decrease in homosexual behavior, does not imply a similar level of change in other areas.

Although the American Psychiatric Association no longer considers homosexuality to be a psychiatric disorder, it is seen by some as adaptive. The term "ego-dystonic homosexuality" continues to be used to identify those individuals who wish to eradicate their homosexual feelings

and impulses. Nicolosi (1991) has coined the term "non-gay homosexual" to designate this group of persons. As described in the older DSM-III, the term ego-dystonic is used of individuals who evidence a persistent concern directed at changing their sexual orientation. DSM-III diagnostic criteria for ego-dystonic homosexuality included the following:

- A. The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships.
- B. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress. (DSM-III, p. 282)

Historical Overview

The criteria for the classification of homosexuality have been influenced greatly by societal opinions throughout history and as a result have undergone much change. Augsburger (1984) presented a systematic, historical explanation of the term homosexuality, in which he included Biblical usages of the word and associated terms. He concluded that the term, as it is used currently in the literature, i.e., based on distinctions between identity and behavior, bears little resemblance to the views espoused in earlier literature.

During the late eighteenth and early nineteenth centuries, categorizing homosexuality was based more on whether an individual was intrinsically homosexual than on

involvement in certain sexual practices. It was assumed that such people are subject to a congenital anomaly in their biological sex, and are therefore not exhibiting deviant sexual desire. In the later nineteenth and early twentieth centuries, this same phenomenon was labeled "gender inversion," a term which had its roots in the medical field. The term signified a permanent inversion of sexual impulses, whereas "perversion," used primarily in moral discussions of homosexuality, focused on what were considered to be immoral sexual activities. At this time, "essentiality" became an important concept as well, a term implying that male homosexuals were essentially female and female homosexuals essentially male (Richardson, 1983/1984). In this view homosexuality was considered a state of being, not a form of behavior.

Freud (1962) joined in the attempt to understand homosexuality, influenced strongly as he was by biological theories of human bisexuality. He noted that embryos have characteristics of both genders prior to the release of sex-determining hormones. The theory served as a continuation of the "essentialist" idea, but Freud expanded the assumption of physical bisexuality to include a psychological component of the same. The phenomenon of homosexuality is determined by the presence of desire for the same sex object. Freud (1962) cautioned, however, that

We are in the habit of regarding the connection between the sexual instinct and the sexual object as more

intimate than it in fact is. . . . It seems probable that the sexual instinct is . . . independent of its object; nor is its origin likely to be due to its object's attraction. (pp. 13-14)

Freud suggested that homosexuality is an outgrowth of being a sexual person, "a kind of reflection of the subject's own bisexual nature" (p. 10), with psychic energy invested in individuals of the same gender who combine characteristics of both sexes.

In contrast to Freud's thinking, behaviorists disagreed with the assumption that homosexuality could be characterized by intrapsychic phenomena and maintained that identification of homosexuality is based solely on observable, behavioral manifestations. This shift in focus has had lasting implications for the classification of homosexuality, as seen particularly in the DSM-III criteria indicated above. Some theorists have added an element of responsibility and choice to the idea of overt behaviors, suggesting that homosexuality is overt, acted-out behavior

in which the individual . . . habitually seeks and attains orgasm by means of sexual contact with a member of the same sex over a period of years, because of choice or preference for a sexual partner of the same sex. (Cappon, 1965, p. 7)

More recently, homosexuality has been understood as a means of personal identification, a classification that originated within the homosexual community itself; it is referred to also as the "identity construct model" (Richardson, 1983/1984). In her summary of the literature incorporating this view, Richardson inferred that an

individual's sexual identity is not based on any enduring core characteristic that was determined by early childhood experiences. The goal of the identity construct model is not to determine the causal factors related to sexual orientation; instead, its aim is to understand the ongoing process by which individuals construct and maintain their sexual identity, considering the influence of social interactions and experiences (Plummer, 1981).

Harry (1984) also agreed that sexual orientation is based on sexual preferences and attitudes, that is, on erotic feelings and attraction, rather than on specific behaviors. He, among many researchers and clinicians, suggested that homosexuality is established early in childhood and remains largely unchanged in adulthood.

A consideration of homosexuality would be incomplete without a discussion of the Biblical issues. At the present time, there are varying opinions within the religious, and even the evangelical Christian, communities regarding the Bible's statements about homosexuals. Some theologians and other individuals in the church have placed homosexuality in the same category as all other forbidden pre- or extramarital sexual practices. They have supported their understanding with statements in the Bible that have traditionally been understood to regard homosexuality as a sinful practice, with harsh consequences unless denounced and discontinued (e.g., Genesis 19--the account of Sodom and

Gomorrhah; Leviticus 18, 20; Romans 1, New American Standard Bible).

Those holding to this conservative perspective have stated that homosexuality, as with any other sin, is not limited to its visible manifestations alone. The reasoning follows that God knows the thoughts and intent of each person and, therefore, judges his or her feelings, behaviors, and thoughts with equal weight (Matthew 5:22, 28, NASB). "For as he (a person) thinks within himself, so he is" (Proverbs 23:7, NASB). The concept of God's discipline, which is meant to eradicate the grip of the sin nature in the individual's life, i.e., disobedient thoughts and actions, applies as well to those who practice homosexuality: "Compulsive behavior [a quality that characterizes some homosexual interactions and relationships] is not immune to the scrutiny of eternal judgment" ("Open Letter," 1991, p. 11).

Many in the religious community, however, view homosexuality as among the most heinous sins and often avoid anyone who admits to having a homosexual orientation. The suggested solution for a person struggling with homosexual feelings, while professing to be a Christian, is to simply stop thinking or acting out of sheer will power in accordance with the homosexual inclination (White, 1977). It is this attitude that many in the gay community consider

dangerous because of their perception that it perpetuates intolerance and homophobia (Bell & Weinberg, 1978).

Another segment of the Christian sub-culture does not condemn homosexuals, because they view redemption of the individual as progressive and do not assume that homosexuality can be disavowed by an act of the will alone. Moberly (1983a) pointed out that:

sexual sin is contrary to God's intention, but homosexuality, although often an occasion for sexual sin, is essentially a state of incomplete development. It is the incompleteness that is contrary to God's intention here. Homosexual acts are prohibited, not because they repudiate the man-woman relationship, but because sexual expression is not appropriate to pre-adult relationships. (p. 28)

Moberly understands the homosexual orientation as one aspect of personality development in an individual's overall growth process and part of spiritual maturation. Those who hold this opinion accept the homosexual and abstain from judging him or her, while still offering hope and motivation for those homosexuals who wish to change. In this view, the issue of sexuality is similar to any other aspect of life that needs God's intervention and assistance for growth or change (Augsburger, 1984; Stafford, 1989).

A third view in the religious community does not consider the homosexual identity as incompatible with Biblical teachings and therefore sees change of orientation as unnecessary. Even here there is found a range of attitudes regarding homosexual behavior. For example, the organization, Evangelicals Concerned, denounces promiscuous

sexual activity, but sanctions, and even encourages, monogamous homosexual relationships, often referred to as "covenant relationships" (Blair, 1978; Campolo, 1988; Regas, 1990).

Supporters of this position have interpreted the portions of the Bible that speak of homosexuality from a much different perspective than is traditionally accepted. In the account of Sodom and Gomorrah, conservatives relate God's harsh judgment to the apparent homosexual attitudes and activity that were occurring in those cities, exemplified in sexual overtures made toward Lot's guests. Those with more liberal views of Biblical interpretation state that the sin was inhospitality, not homosexuality (Benson, Clark, Evans, Felton, Fleming, Gadd, Newsom, Rusch, & Thyne, 1991; Olson, 1984).

In summary, it is evident that there is a wide range of conceptualizations regarding the source and nature of homosexuality. Because the etiology of homosexuality is still in question, several relevant theories are addressed in the following section.

Etiology

Three theories have been prominent in discussions of the etiology of homosexuality: (a) physiological/genetic, (b) social, and (c) psychoanalytic. Augsburger (1984) added to them volitional and moral theories, while Moberly

(1983a, 1983b) and Siegel (1988) offered theoretical material loosely based on Object-Relations theory. Because Augsburger (1984) provided a thorough exposition of these major theories, the present review focuses in-depth on the Object-Relations conceptualization after only summarizing major etiological views. This is followed by a review of current research. Neill's (1987/1988) conclusions regarding the influence of family and parental characteristics on the development of the homosexual identity are integrated where applicable.

Physiological and Genetic Factors

The assertion of genetic predisposition to homosexuality has had a longer history of research, testing and discussion than any other scientific theory of the etiology of homosexuality. In the late nineteenth century, Krafft-Ebing (1965) proposed that a type of male/female substance, through its influence on brain composition, caused an innate disposition called homosexuality. Since that time other theorists have argued for the presence of constitutional factors, particularly focusing on brain activity (Socarides, 1978). However, studies attempting to link homosexuality to genetic or hormonal factors have not produced conclusive evidence.

It was in the 1940s that questions were first raised concerning the influence of hormones on the subsequent development of homosexuality. Glass (1940) concluded that

hormones are unable to change the pattern of sexual drives, although they do have an influence on their intensity. More recently, the focus has been upon the effects of testosterone levels. Results have indicated that homosexual males do not evidence consistently lowered levels of testosterone when compared with levels in heterosexual males. It appears that the development of homosexuality cannot be explained solely by endocrine dysfunction (Kolodny, Masters, Hendrix, & Toro, 1971; Tourney, Petrilli, & Hatfield, 1975).

In 1991, LeVay reported his findings after studies analyzing the anterior hypothalamus of each of 41 cadavers (19 gay males--all of whom had died of AIDS, 16 straight males--six of whom had died of AIDS, and six straight females--one died of AIDS). The anterior hypothalamus is a structure of the brain that, in addition to heart rate, hunger and sleep, regulates sex drive. LeVay discovered that one bundle of neurons composing that area of the brain (referred to as INAH-3) was approximately three times larger in heterosexual men than in homosexual men and heterosexual women, and that its anatomical form in the homosexual men was more similar to that usually found in women.

LeVay (1991) concluded that "INAH is dimorphic with sexual orientation, at least in men, and suggests that sexual orientation has a biological substrate" (p. 1034). However, the results presented in LeVay's Figure 2 revealed

that the INAH-3 volumes for 3 of the homosexual males were more comparable to those of heterosexual males (0.125-0.20 cubic millimeters), while the size of neuron bundles for 3 heterosexual males fell in the range found for most of the homosexual subjects (0.00-0.05 cubic millimeters). He admitted, therefore, that the data in his study cannot be manipulated to show conclusively that sexual orientation is the determinant of INAH size and that his study cannot be construed as establishing definitively the direction of causality.

Some have been quick to use LeVay's findings to dismiss any suggestion that homosexuality represents a psychiatric disorder or deviant lifestyle rather than a biologically determined aspect of personality. The research community has maintained a cautious view of LeVay's study (Barinaga, 1991). Concerns have been raised regarding the validity of LeVay's conclusions, given the fact that the majority of the subjects died of AIDS. This suggests the possibility that the differences shown in the study were merely artifacts of the disease not necessarily explainable by homosexuality.

To address this issue, LeVay discovered that the heterosexual male's hypothalamus was proportionately larger than in the homosexual male and heterosexual female, regardless of the cause of death, including death from AIDS. His report, however, did not acknowledge that the course of the disease varies from individual to individual,

not only in its duration (a factor LeVay did consider in his study), but also its morbidity in respect to discrete areas of brain and bodily function.

Additional criticism of LeVay's study stems from the difficulty in measuring such small samples of brain tissue, as well as in determining the unit of measurement upon which neuroscientists do not agree, i.e., volume of the region vs. number of individual neurons in the bundle. LeVay (1991) stated clearly that "no attempt was made to measure cell number or density" (p. 1036). Others have reserved final judgment on this issue and its implications until a further study can replicate the results (Begley & Gelman, 1991).

Most recently, Bailey and Pillard (1991) published a study of male twins which attempted to determine whether homosexuality has a genetic component. In their sample of 110 males, these investigators discovered a concordance rate of 52% (29 of 56 males) among identical male twins, whereas only 22% (12 of 54 subjects) of fraternal twins exhibited a homosexual orientation--based on whether one of the twin brothers had adopted a gay lifestyle. Among those in the control group, which consisted of the adoptive brothers of 57 gay males between whom there was no genetic link, it was found that only 11% (6 subjects) claimed to be homosexual. This statistic is comparable with statistics that have been assumed regarding the incidence of homosexuality in the general population.

The primary criticism of the methodology in the Bailey and Pillard (1991) study focuses on the fact that the twins were raised in the same home, which suggests that each boy was exposed to similar familial and social interactions. Because genetic factors cannot be separated from the influence of the home environment, the strength of the study's conclusions would seem to be diminished. Bishop (1991) pointed out that "because almost half the identical twin brothers and almost four-fifths of the fraternal twin brothers weren't gay, the study shows that genes don't cause homosexuality but only that genes make it more likely for some men to become homosexual" (p. B4). Bailey and Pillard concluded that their study provides "some support for the view that sexual orientation is influenced by constitutional factors" (p. 1095).

Regardless of the methodological problems and the large numbers of research subjects whose homosexuality could not be explained by genetic factors, some have interpreted Bailey and Pillard's results in what may be an overly generous and optimistic manner. For example, Knox (1991), in his assessment of the article, expressed the view that the "study of homosexuality in twins . . . has provided new evidence that sexual orientation is largely inborn, not primarily a matter of upbringing or choice" and that "genetic factors are responsible for 30-70 percent of male homosexuality" (p. 20). Although Knox has conceded that

these figures leave "some room" for familial and environmental influences, his implication remains that homosexuality is largely biologically determined.

In response to Knox's (1991) critique, LeVay (1991), whose own research on the hypothalamic region of the brain brought renewed discussion of biological factors influencing the development of homosexuality, stated that "there's a strong feeling out there in the straight world that sexual orientation is a matter of choice, a chosen lifestyle, and not something inborn" (p. 20). LeVay and other advocates of the gay lifestyle take this as stronger evidence that homosexuality is innate, consequently anticipating a drastic change in people's attitudes when they finally realize that homosexuality is not a matter of choice. Such conclusions, however, cannot be inferred without qualification from Bailey and Pillard's (1991) findings, though used in an attempt to preclude most discussion of the issue of personal responsibility as it pertains to homosexual activity.

Social Factors

The proponents of social factors as the etiology of homosexuality focus primarily on the idea that homosexual individuals have internalized inappropriate sex roles, that is, sexual roles that deviate from those societal norms which place greater value on heterosexuality. Proponents of this view suggest that the homosexual orientation is caused, in part, by society's failure to provide sufficient

definitions for sex roles and, in part, by the individual's failure to appropriate available sex roles (Powell, 1974).

Poole (1970) asserted that

adult sexual orientation is established in the early formative years through the learning process, and most especially through the acquisition of significant symbols as they relate to erotic inclination. . . . In this manner a particular erotic orientation is built up, and once being established it crystallizes as a permanent part of the individual's sexual-social inclination. (p. 54)

In his research with a lesbian population, Poole (1970) discovered that a mother's negative attitudes toward sexuality, combined with a lack of positive role modeling as wife and mother, and little personal influence on the developing female child, were key factors related to the child's later aversion to adult heterosexual relationships. Marmor (1980) suggested that many male and female homosexuals were raised with at least one parent holding strong anti-heterosexual, puritanical attitudes.

Poole (1970) also noted that opportunities for role-playing, such as "playing house" or pretending to be a mother with a baby--behaviors typically seen in latency age girls--were lacking by a significant margin in the background of most of the lesbian subjects compared to their heterosexual counterparts. Dorpat (1988) has remarked that Siegel's (1988) clinical work with 12 lesbians revealed a similar pattern: "All of her female homosexual patients were uninterested as children in their dolls or in the usual games of childhood" (p. xvii). According to Poole (1970),

"while the mother's attitude on the subject of sex is very important in the development of adult sexual behavior, the role of learning activity is the more predominant factor" (p. 92).

The father's role, although apparently not the primary factor in the development of adult female sexual orientation, has considerable influence on the daughter, particularly if it adds to, rather than counterbalances, the negative attitudes and role-modeling of the mother. Poole (1970) explained that:

An influential father who provides his daughter with a positive emotional experience in relationship to himself engenders in his daughter the desire to recapitulate, in part at least, the earlier experience, and thus as she matures she is motivated to associate with males and attain from them similar positive emotional responses. (p. 143)

It is apparent in reviewing the social theory literature that greater emphasis is placed on parental figures, rather than on society at large, as the essential role-models impacting the developing child's gender identity formation. Hampson (1965) summarized this issue, stating: "It appears that both normal and deviant gender role establishment is markedly influenced by the salient behavioral features of the role model" (p. 125). Classical psychoanalytic and psychodynamic theories also consider the influence of parents as primary, but with a focus on the emotional climate they provide for the child through relationships. However, the child's perceptions, intrapsychic conflicts,

and responses are regarded as equally important, if not even more crucial, in the development of gender identity.

Psychoanalytic Theory

The perspective of psychoanalytic theory with respect to homosexuality focuses on the infant's and child's experiences with family members, experiences both actual and perceived, which later influence other interpersonal relationships. Freud theorized that homosexuality develops from unresolved conflict in the Oedipal stage, a time in personality development when a child purportedly begins to love the parent of the opposite gender and feels competition with the same gender parent. The child's desire for the opposite-sex parent, interpreted by Freud as an attempt at developing an incestuous relationship, typically engenders fear of retaliation to the point of annihilation by the same-sex parent. Under typical circumstances, the child resolves that fear and anxiety by focusing psychic energy on, and identifying with, the same-sex parent in order to obtain a spouse similar to the opposite-sex parent in the future.

Interpretation of Freudian theory suggests that for the male homosexual the fear of father ("castration anxiety") having been too great, results in identification with the mother. However, another interpretation of Freud's work suggests that male homosexuality is the result of the boy's attempts to assuage the father's anger and diminish his anxiety by convincing father of his total lack of interest

in women (i.e., mother). He sets out to accomplish this by pleasing his father and uniting only with him or with others similar to him (Gershman, 1975).

For the lesbian and heterosexual female, Freudian theory implies that the Elektra Complex and "penis envy" were never fully resolved, leaving women in a state of limbo with regard to identity and personal fulfillment. Freud's assumption was that unless a woman is able to find her completion by obtaining a penis (through a heterosexual relationship) and giving birth to a son, she is left with feelings of inferiority and genital deficiency (Siegel, 1988).

In more recent, modified versions of psychoanalytic theory, the concept of the Oedipal complex has been given less importance, while the relationship with both parents has received greater attention (Bieber, 1976; Hatterer, 1970). Some hold that the development of homosexuality is a function of having a hostile, emotionally distant father (Freund and Blanchard, 1983; Herron, Kinter, Sollinger, & Trubowitz, 1980) and an over-protective, intrusive mother (Poole, 1970). Bieber et al. (1962) stated that the typical homosexual male in their study generally had a "seductive" and "close-binding-intimate" mother and "hostile-detached" father. These parental personality characteristics had a profound influence on interactions with the son, increasing the likelihood of his becoming homosexual.

Siegelman (1981b) discovered that lesbians, more often than heterosexual women, described both parents as "rejecting" and their fathers as less protecting and loving. In Neill's (1987/1988) review of the literature, she stated that "fathers of homosexuals were perceived in both cases [i.e., in reports from both gay men and lesbians] as weak, absent, hostile, and lacking in affection. Mothers of homosexual males were seen as dominant, restrictive and over-controlling, while females viewed their mothers as rejecting and lacking in love and affection" (Neill, 1987/1988, p. 22).

The male child's sense of self and personal adequacy is undermined or stunted by the father's hostility or lack of involvement and the mother's excessive desire to protect and help. In this environment, the male child does not have an adequate male role model with which to identify, while the mother provides a sense of security without allowing the necessary separation and individuation. Acosta (1975), citing Freud's and Fenichel's concept of homosexuality, concluded that

disturbed parent-child relationships are considered to lead the child's failure to successfully go through the identificatory processes of 'anaclitic identification' and 'defensive identification.' The consequence of this failure is likely to be homosexuality which is based on a neurotic fear of heterosexuality. (p. 14)

Socarides (1968) suggested further that the homosexual's identity is an attempt to deal with the anxiety of feeling inadequate by returning to the phase of

undifferentiated sexual identity (symbiosis). In his opinion, homosexuality is the result of an unsuccessful separation and individuation from the maternal figure, resulting in an exclusion of the father as an object of libidinal energy. A similar perspective is proposed by Herron, Kinter, Sollinger, and Trubowitz (1980), following their discussion of therapy with a male homosexual, hypothesizing that he was

still connected to the lack of fulfillment of his symbiotic phase. One of the ways he tries to complete it is by seeking a partner of the same sex because, while the original symbiotic partner was mother, to the infant (and still to the patient), the mother of that time was primarily himself [an extension of himself]. In that sense she was male, and so he continues to seek a partner who by being male, . . . will be a self-replica and will provide him with an unfulfilled part of himself. (p. 399)

Malmquist (1978) noted that elements of extreme dependence in combination with hostility toward parents are common attitudes related to the development of homosexuality. Others have theorized that "girls may be predisposed to homosexuality by a hatred and rejection of their mothers which leads them to other women for warmth and acceptance" (Acosta, p. 14-15).

In response to the previously mentioned concepts, many theoreticians question the validity of such observations and deny the implication that homosexuality is a developmental deficit or that it is an evidence of psychopathology. Churchill (1967), in response to Bieber et al.'s (1962) statements, asserted that homosexuality is one method of

normal sexual expression and has no roots in interpersonal and/or intrapersonal conflict or anxiety. Bell, Weinberg, and Hammersmith (1981) suggested that the influence of a particular type of parental relationship is over-stated. On its most basic level, they considered the Bieber et al. (1962) model an inadequate explanation of the development of homosexuality since it cannot be applied consistently to the familial backgrounds of every homosexual individual.

Siegelman's (1974) original study of 307 homosexual males offered support for Bieber et al.'s (1962) constellation of paternal characteristics, but the results of his replication study (Siegelman, 1981a) did not show any significant differences in parental background between homosexual and heterosexual males. Shavelson, Biaggio, Cross, and Lehman (1980), in a comparison of 26 lesbians and 26 female heterosexuals, also found no significant differences in the parent-child relationships or in the parents' adherence to traditional sex-roles. Marmor (1965), therefore, concluded that the parental factors are not sufficiently disparate when comparing the parental influences of heterosexuals and homosexuals.

In his overview of theories pertaining to the development of homosexuality, Acosta (1975) indicated that proponents of psychoanalytic hypotheses have presented few empirical studies which test their accuracy and validity. Lewes (1988) suggested that psychoanalytic attitudes

regarding homosexuality actually have become progressively rigidified and that theories of homosexuality have not been based on "unbiased inspection and ordering of its data, but on the confluence of that approach with historical accident, unexamined moral and social judgment, and the vagaries of the history of psychoanalysis" (p. 230).

Those psychoanalytically based studies that have been conducted have had methodological deficiencies, among which is a reliance on clients' recollections of childhood experiences and past interactions with parents (Boxer & Cohler, 1989; Neill, 1987/1988). With particular reference to the latter, Acosta (1975) voiced his concern about the use of retrospective data: "The present biases which the respondents have about their parents can easily affect the responses which they give about their early childhood [i.e., what and how accurately they remember about the past]" (p. 16). For this reason, definitive statements from the psychotherapeutic community have been received with skepticism, because of the lack of incontrovertible evidence to support them.

Volitional Factors

In Augsburger's (1984) paper, he commented on the lack of literature that discusses the issue of choice as it pertains to homosexual orientation and behavior. His assumption was stated as follows: "Regardless of what the individual's basic constitution and experience may be, he is

able to exercise personal control and thereby be responsible and accountable for his action and thoughts" (p. 67).

Augsburger asserted therefore that, despite the possible influence of past interpersonal interactions and biological factors on the decisions a person makes, each individual ultimately has the freedom to act in a self-determining manner.

Interestingly, within the gay community itself there is disagreement on this issue. Siegel (1988), following her study of 12 lesbians, commented that they all entered therapy under the assumption that their homosexual lifestyle was the result of their free choice. A statement made by Rawlings and Carter (1977) seems to support this viewpoint: "Lesbianism is more than an alternative lifestyle: it is a political statement by women that they are defining themselves independently of men" (p. 254). Maggiore (1988) supported this in her statement that "Lesbianism . . . is not a passive acceptance of a sexual predetermination which manifests itself at an early age without one's knowledge or introspection. Lesbianism is a choice, . . . a challenge to patriarchy" (pp. 45-46). Poole (1970) asserted that

homosexuals are more disturbed by research directed toward the causes of their behavior than other groups. This is particularly true among lesbians of higher levels of education who seem to positively loathe the whole idea of their behavior being "caused." (p. 152)

It would be logical to assume that if homosexuality is not caused, as these proponents claim, it is a choice.

However, such comments are rarely found in literature by male homosexuals, or regarding male homosexuality. On the contrary, some researchers (e.g., Bailey & Pillard, 1991; LeVay, 1991) have continued to investigate biological factors, and sometimes voice their view that homosexuality is not a product of individual choice, but rather an innate disposition.

Siegel (1988) stated that she had "never met a homosexual person, either male or female, who did not appear internally driven toward homosexuality" (p. xiii). Although this may be seen as support for the view that homosexuality is not based on individual choice, even the title of her book reflects that struggle to reconcile the contradictions within the debate: Female Homosexuality: Choice Without Volition. Her thesis is that individuals (i.e., children) may choose an identity or course of behavior in order to adapt to a situation that does not address their developmental needs; however, the choice is not seen as willful decision (volition), but as a means of personal, emotional survival within the family. In the case of Siegel's clients, the high cost of choosing homosexuality under these circumstances has resulted in their being "forever condemned to live without gender-specific identity" (p. 223).

Jones and Workman (1989) stated that "the Christian view would suggest that we respond to these external

influences [e.g., familial and social] with small or large responsible acts of our own, thus adding our own choices to the host of causal factors that shape our personalities" (p. 222-223). In Augsburger's (1984) view, however, the issue of choice may enter at the point where the individual chooses "to commit to the homosexual orientation, but he does not originally choose the homosexual sense" (p. 68).

Moral Factors

In the psychological literature, specifically literature focusing on clinical work, an often neglected issue pertains to the individual as a moral being. Although theories of moral development are discussed as part of normal childhood maturation, often the topic is avoided or minimized in its importance in the context of adult functioning. From an orthodox Christian worldview perspective, this ignores the fact that each person is distinct from other creatures because he possesses a "noble image" as a human being, and functions with "the ability and capability to choose and direct his own life with sensitivity to other realities that surround him" (Augsburger, 1984, p. 72).

Reference is made in this connection theologically to Genesis 1:27, NASB: "God created man in His own image, in the image of God He created him." Augsburger has suggested that the etiology of homosexuality is just one among many manifestations of that image marred by sin and the "fallen

nature." The one aspect of God's image from which humanity falls far short is God's moral nature, specifically--his moral perfection, which he declares about himself in the Scriptures. The Oxford American Dictionary (1980) defines perfection as "1. being complete, having all its essential qualities. 2. faultless, excellent" (p. 495).

Packer (1973) interpreted the following Bible passage as mentioning "all the particular perfections . . . and all that go with them" and "these things together make up God's goodness, in the overall sense of the sum total of His revealed excellences" (p. 146): "The Lord, the Lord God, compassionate and gracious, slow to anger, and abounding in lovingkindness and truth; who keeps lovingkindness for thousands, who forgives iniquity, transgression and sin; yet He will by no means leave the guilty unpunished" (Exodus 34:6-7b, NASB). Other references reveal the understanding of God's people regarding his transcendence: "As for God, His way is blameless," i.e., complete, having integrity (Psalm 18:30, NASB).

Within the frame of reference of God's moral completeness, there is a responsibility which attaches to having been created in the image of God: "Therefore, you are to be perfect, as your heavenly Father is perfect" (Matthew 5:48, NASB). Although this may seem an unreasonable expectation for human beings, maturation in the direction of the image of God is both possible and expected:

As obedient children, do not be conformed to the former lusts which were yours in your ignorance, but like the Holy One who called you, be holy yourselves also in all your behavior; because it is written, "You shall be holy, for I am holy" (i.e., set apart for God's purpose and will, different). (1 Peter 1:14-16, NASB)

As the Scriptural writer points out, the existence of "former lusts," evidence of the fallen nature which must be addressed, includes homosexual lusts. This Bible passage also implies that an active decision must be made in order to change feelings and conduct in any given area, regardless of the cause of the problem. Hays (1991) has pointed out:

We must reject the apparently common sense assumption that only freely chosen acts are morally culpable. Quite the reverse: The very nature of sin is that it is not freely chosen. We are in bondage to sin but still accountable to God's righteous judgment of our actions. . . . It cannot be maintained that homosexuality is morally neutral because it is involuntary. (p. 20)

Augsburger (1984), distinguishing between homosexual disposition and homosexual behavior, stated:

With regard to moral relevance, behavior falls more under personal control than does disposition. . . . Hence, it is not the question of the condition of the individual with a homosexual sense any more than it is the question of any other man's condition. The matter rests with the moral direction of the life. (pp. 73-74).

Therefore, any activity or attitude contrary to this moral direction, sexual or otherwise, prevents the process of conforming to God's image. Hays (1991) summarized the homosexual dilemma in this manner: "The gay subculture encouraged homosexual believers to 'draw their identity from their sexuality' and thus to shift the ground of their

identity subtly and idolatrously away from God" (p. 17). It is at this point, according to orthodox Christian theology, that God's forgiveness, redemption and renewal are needed and available for all human conditions, including homosexuality.

Object-Relations Theory

Moberly (1983a, 1983b, 1985) has examined homosexuality from both the psychological and Christian perspectives by reassessing previous psychoanalytic data as a result of observing patients in the clinical setting. Her disagreement with previous conceptualizations pertains to what she sees as an artificial and useless distinction between orientation and activity. Instead, she has attempted to determine whether a particular type of personality allows for the possibility of developing homosexuality.

In Moberly's view (1985), "the homosexual condition is to be linked--not with genetic predisposition, hormonal imbalance or even abnormal learning processes as commonly understood--but with difficulties in the parent-child relationship, especially in the early years of life" (p. 206). She has contended as well that a person's homosexual orientation is not the product of fear or renunciation of the opposite sex, as other theorists have affirmed, but is rather the reflection of unmet psychological and emotional needs which have precluded the

individual's attainment of same-sex identification and heterosexuality.

In a similar vein as modified psychoanalytic theory, Moberly has asserted further that both males and females with a homosexual orientation have experienced some deficit in their relationship with the same-sex parent and, in order to compensate for such deficits, they engage in homosexual behaviors. Although some theorists in the past have taken a similar line of thinking and extrapolated blame to one or both parents (Bieber et al., 1962), Moberly (1983b) has emphasized that blame, if it is even helpful to ascribe it to anyone, can neither be placed on one person definitively nor considered a primary focus of the overall issue. The nature of the deficit, whether actual or perceived, intentional or accidental, by omission or commission, has resulted in unmet psychological needs in the life of the homosexual and a continued attempt to fulfill them. "The young child's need for attachment to the parent of the same sex has been thwarted and hence has persisted as a love-need that still requires fulfillment" (Moberly, 1983b, p. 19).

What further complicates the issue is that the child, as a consequence of the felt deficit, reacts with repeated avoidance of, and withdrawal from, the same-sex parent, who is experienced as hurtful; this minimizes or precludes any subsequent positive development of the relationship. Not only is the attachment between the parent and child

disrupted, but the child avoids reparation of the attachment, to which Moberly refers as a "defensive detachment." The detachment, however, is counterbalanced by the continued desire to have psychological needs met by the same-sex parent ("same-sex ambivalence"), thereby creating an "approach-avoidance" conflict. Whereas the previously stated theories have attempted to explain homosexual behavior in negative terms (i.e., what was lacking or what occurred that was damaging), Moberly has attempted to understand both the dilemma and goal which underlie the behavior. In her view, the homosexual drive is moving toward reparation of the lost relationship, which Moberly considers a positive factor, although the manner in which the repair is attempted perpetuates the detachment. Moberly (1983b) has stated that

the homosexual response is not itself a problem, but rather the attempted solution of an underlying problem. The problem is the disruption of the child's libidinal bond with the parent of the same-sex. . . . The homosexual response aims at restoring and completing this process of growth, the end result of which is indeed heterosexuality. (p. 47)

The process of detachment has important implications for gender identification and orientation. The individual, as Moberly has formulated her view, "dis-identifies" him- or herself from the parent of the same sex as a pathological mourning response to childhood trauma (e.g., early and/or extended separation from parent), rather than identifying with the opposite-sex parent. The attachment to the

opposite-sex parent becomes stronger, not weaker, as in Freudian theory, as a result of the same-sex detachment. The homosexual struggle is primarily a flight from the same-sex rather than a positive choice to seek opposite-sex relationships.

The individual is faced with the result of the defensive detachment and same-sex ambivalence: unfulfilled psychological needs for attachment with members of the same sex and inability to have those needs met in an appropriate manner. "The homosexual condition does not involve abnormal needs, but needs that have, abnormally, been left unmet in the ordinary process of growth. The needs are normal; their lack of fulfillment, and the barrier to the fulfillment, is abnormal" (Moberly, 1983a, p. 18).

A question surfaces logically at this point, that is, why would not a homosexual relationship be sufficient to fulfill the needs left unmet in the relationship with the same-sex parent. Although Moberly has allowed for the possibility that such resolution not only can but has taken place in some homosexual relationships, she has proposed a scenario which typifies some likely obstacles when reparation is sought in this manner. In her scenario, the initial attraction is to an individual who possesses physical or personality characteristics that an individual feels he or she is lacking.

The relationship and sexual interactions become the means by which the person hopes to acquire vicariously certain desired traits and a sense of masculinity or femininity (in the male and female homosexual, respectively) (Pattison & Pattison, 1980). In this connection, Moberly has theorized that "The essential 'feminine wishes' involved in lesbianism are the desire for a libidinal attachment to the female (mother), i.e., the desire for the medium through which a mature feminine identity may be attained" (Moberly, 1983b, p. 57). Likewise, for the male homosexual, his "love for men is but the thwarted love for his father, i.e., it is a masculine and an identificatory love which is intimately linked with the building of the boy's gender identity . . . the reparative urge towards the restoration of the identificatory process" (Moberly, 1983b, p. 42). Because each partner has similar developmental and relational needs as the other, they therefore cannot fulfill those needs for the other to the degree that he or she wants or feels necessary.

At the same time, the tendency to be defensively detached from members of the same sex often resurfaces and has a disruptive influence on that relationship as well, causing further instability and mistrust in future same-sex relationships. As the need for relationships with those of the same gender becomes eroticized, the distinction between infantile needs for contact and emotional support and mature

desire for sexual contact becomes confused and blurred. As formulated by Moberly (1983b):

Psychological needs that are essentially non-adult remain in a person who is in other respects adult. But to attempt to meet these psychological needs through the medium of sexual expression is to mistake the character of these needs. It is understandable that someone who has attained physiological maturity should interpret libidinal needs as sexual. However, this secondary eroticisation of outstanding deficits in growth is essentially a confusion: the emotional needs of the non-adult are confused with the physiological desires of the adult. (p. 83)

Siegel (1988), in a study based on analytic therapy with 12 lesbian clients, has developed a theory of the etiology of female homosexuality with elements quite similar to those of Moberly's formulation. Siegel indicated that her clients had never completed successfully the oedipal phase of development, a factor which was confirmed by little or no evidence of structural conflicts (i.e., between the id, ego, and superego) commonly associated with that phase. She stated that "in these women the Oedipus complex remained vestigial at best, with little or no acknowledgment of the desire to 'have' father, his penis, or a baby" (Siegel, 1988, p. 8).

From the same vantage point, Dorpat (1988) has stated that "the conflicts experienced by these homosexual women are predominantly object-relations conflicts stemming from preoedipal phases of development, rather than structural conflicts arising from the oedipal and later phases" (p. xx). Newman (1976), in his therapeutic work with

"feminine boys," agreed that his clients had not evidenced the typical conflicts that characterize the oedipal phase. He pointed out that without treatment intervention, a boy with a strong preoedipal feminine orientation has the potential to develop a more entrenched gender disturbance (e.g., transsexualism).

With heavy reliance on the theories of Mahler and Kohut, Siegel suggested that her clients had not resolved the conflicts inherent in the separation-individuation phase of their early development. The result was their inability

to include both parents in their libidinal strivings. The delusional omnipotence of the toddler was unmodified . . . so that in these adult women the fear of object loss and body boundary disintegration increased awareness of bodily (but not genital) feelings, and unconscious denial of the difference between sexes remained near their original, primitive strength. (Siegel, 1988, p. 13).

Siegel has incorporated the Kohutian concept of "mirroring," a process which begins at birth as the mother welcomes her baby "as potentially like herself and . . . transmits her joy in refinding her own infant self in the little one" (p. 21). In contrast to this scenario, Siegel hypothesized that her clients' mothers communicated non-acceptance of the female infant through overt displeasure or depression, which resulted in the daughter's impoverished and distorted self-image as a female in her own right. Therefore, "the little girl who later turns to homosexuality never has a chance to create her true self. She is a creation of her mother,

whose self-love she was meant to enhance, instead of the other way around" (Siegel, 1988, p. 22).

As a result of each daughter's need to focus on her mother's needs, the process of female identification (i.e., being female and feminine) was truncated to a great degree. The research of LaTorre and Wendenburg (1983) showed only one significant difference between heterosexual and homosexual women, that is, homosexual women not only evidenced femininity less but tended instead toward androgyny. Shavelson, Biaggio, Cross, and Lehman (1980) found that the lesbian women in their study exhibited greater masculine sex-role behavior than heterosexual women.

Continuing her discussion, Siegel (1988) stated: "In particular, identification with inner genital spaces [i.e., the internal representation of the vagina] became impossible because the mothers themselves had not developmentally made the link between their own inside space, motherhood, and the external product--their daughters" (p. 220). Rather, in light of what they observed of their mothers, as individuals and in relationships with males, these clients perceived that it was "unacceptable, even dangerous, to become like their mothers" (p. 203). Therefore, the lesbian relationship, for these women, was a means of finding

'another like myself [who] must show me that I have a sexual self.' . . . But the mirroring they received in such encounters was as distorted in a different way as their primal, maternal one had been, and thus they were

locked in the neverending cycle of the repetition compulsion. (Siegel, 1988, p. 204)

In a similar line of thinking, Bieber (1976) stated:

"Psychodynamically, [the male homosexual direction] is a way of defending against attack by aggressive males, assuaging feelings of paternal rejection and restoring a defective sense of masculinity" (p. 164). However, regarding the acquisition of identity, Moberly (1983b) countered, "It is not the mother's self-image or her attitude towards her daughter's gender role that affects the daughter's femininity but the daughter's own capacity for relationship to her mother" (p. 65). Without diminishing the impact of the parent-child relationship (and early trauma) on this capacity, she might agree with Siegel's conceptualization of homosexuality as a "choice without volition."

Multiple Factors Regarding Etiology

Any discussion regarding the etiology of homosexuality should demonstrate not only the continued level of interest it engenders within scientific and clinical research communities, but the unresolved nature of the theoretical debate as well. Many would concede that some individuals seem to have biologically predisposing factors associated with development of a homosexual orientation, although the emergence of those factors is highly dependent on parental and societal influences, particularly during the years of early development (Acosta, 1975; Bell, Weinberg & Hammersmith, 1981). Money (1980), often cited as supporting

a genetic/hormonal theory of homosexual development, offered this clarification:

Available evidence supports a nongenetic hypothesis for the origin not only of homosexuality, but of psychosexual differences and variations of all types. Prenatal hormonal determinants probably do no more than create a predisposition on which the postnatal superstructure of psychosexual status differentiates, primarily, like native language, under the programming of social interaction. (p. 70)

Green's (1987) work demonstrated the likelihood that a homosexual orientation is the result of a combination of genetic, familial and societal factors. Through his 15-year prospective study with two groups of boys and their parents, he attempted to trace the development of both heterosexual and homosexual behavior, particularly interested in what he refers to as the "sissy-boy syndrome." The individuals of both groups, varying in age from 4 to 12, and their parents were interviewed as to their inclinations regarding gender identity and gender-role, as well as preferred activities. One group of 56 boys, during the initial interview, presented typically "masculine" attitudes and preferences for their age. The other group (66 "feminine" boys) indicated that they wanted to be female, often dressed in girls' clothing, played with dolls, role-played as girls or women, and avoided rough-and-tumble activities or sports. The "feminine" boys' cross-gender behaviors generally were accompanied by cross-gender identity issues as well.

The results at the conclusion of Green's (1987) study revealed that, of the two-thirds of the subjects interviewed

in young adulthood (35 "masculine" and 44 "feminine" from each of the original groups), all but one of the members of the first sub-group were heterosexual. In contrast, approximately three-fourths of the second sub-group were either homosexual or bisexual (i.e., 50% of the original sample). Although this evidence may be seen as offering support for a biological basis of homosexuality, Green concluded that the role of parents has considerable influence on the early development of gender-role preferences and gender identity, which have the potential to be precursors of the homosexual orientation in adolescence and adulthood. Green also discovered that the parents' perception of the child's appearance at birth ("beautiful") and subsequent parental reactions to the infant (e.g., wish for a girl, less time spent with the child by both mother and father, not encouraging traditionally masculine activities) correlated significantly with later development of homosexuality. Neill (1987/1988) provided similar data in her literature review of both paternal and maternal influences on gender identity development.

Bailey and Pillard (1991) also attempted to assess the relationship between childhood gender nonconformity (denoted as CGN, comparable to the constellation of "sissy-boy" behaviors of Green's study) and the heritability of sexual orientation among subjects in their twin study. They hypothesized that "homosexuals with CGN should have a

greater genetic loading, and hence should have a higher rate of homosexual relatives, or if twins, should be more likely to have homosexual cotwins" (p. 1090). Subjects with homosexual relatives were not found to be significantly different from those with heterosexual relatives in any of the three experimental groups (i.e., identical twins, fraternal twins, adoptive brothers) on the basis of CGN. However, monozygotic twins concordant for homosexuality were more likely to be concordant in degree of CGN. The results suggest that "individual differences are largely determined by genetic and/or shared environmental factors, . . . [but] emphasize the necessity of considering causal factors arising within the individual, and not just his psychosocial environment" (Bailey & Pillard, 1991, p. 1095).

A boy manifesting the above-mentioned constellation of behaviors and thoughts (CGN) likely would be labeled a "sissy" by male peers and society, and quite possibly by family members as well. The Saghir and Robins (1973) study showed that two-thirds of their male homosexual subjects, compared with only 3% of the male heterosexual controls, recalled displaying a "girl-like" syndrome, while 70% of lesbians (as opposed to 16% of heterosexual females) labeled themselves as "tomboys." Saghir and Robins also discovered that all of the homosexual male respondents who were effeminate in childhood were "called sissy and teased by

their schoolmates. . . . an unhappy experience that most of them recalled very vividly" (p. 19).

It would not be surprising that, in reaction to the ridicule and rejection for being different and the resulting social isolation from male role-models, the feminine boy may deny his masculine identity. Although Green (1987) made it clear that neither biological factors nor socialization alone explain the development of homosexuality, he did propose that, along with such influences,

early cross-gender behavior, at a critical developmental phase, establishes an "incubation period" for later expression of homosexual arousal. As long as the boy's behavior is cross-gendered during this period, homosexual arousal will emerge years later, irrespective of the pattern of gender-role behaviors during the intervening years. (p. 388)

Again, the evidence as to causality is inconclusive, and the variability among the results does not explain the data for at least one-fourth (and potentially up to 50%) of the remaining "feminine" boys not interviewed in adulthood. As with most of the literature, Green suggested a combination of "innate contributions of the child, psychological features of the parents, and sociological patterns of the environment" (p.381) as contributing toward the development of homosexuality, with considerable emphasis on the parent-child relationship and its impact on gender identity.

The influence of interpersonal interactions on the development of sexual orientation becomes particularly complicated when a history of sexual abuse is involved.

Much of the literature published prior to the 1980s did not address the abuse issue nor acknowledge any correspondence between sexual abuse and a homosexual orientation (Payne, 1981; Stafford, 1989). However, Caprio (1954), in his consideration of Freud's theory of the development of homosexuality (i.e., defense against incestuous longings), suggested that the anxiety produced by heterosexual contact might have some basis in real-life experience: "It was not too uncommon to learn that an older brother had sexually accosted his sister, paving the way towards the development of her flight from heterosexuality to homosexuality" (p. 111). In simplistic terms, he viewed the development of a lesbian orientation in some women to be the result of her reaction to sexual trauma, including incest and rape.

Payne (1981) agreed that "not all lesbian behavior is primarily connected with this early failure to be in a trusting and loving relationship to the mother" (p. 29), but asserted that traumatic experiences in childhood, such as rape, might contribute to the development of a lesbian identity. Although anecdotal material has been reported, primarily by females, in support of this theory, availability of empirical data has been minimal (Allen, 1987; Hardin, 1985). However, this further suggests the likelihood of multiple factors contributing to the development of homosexuality, with considerable influence from familial and societal interactions.

Treatment

A review of the literature pertaining to any area of homosexuality would reveal predominant focus on the male homosexual population, with significantly less discussion and acknowledgment of lesbian issues. To the women of the gay community, this lack of viable research implies that data regarding men are considered valid for, and directly applicable to, women or, worse yet, that their existence as a sub-culture is being virtually ignored. Escamilla-Mondanaro (1977) interpreted this "dearth of information regarding lesbianism [as a reflection, in part, of] this society's attitude of deeming women and their activities less valuable and thereby less worthy of investigation than men" (p. 256). Others (e.g., Riddle & Sang, 1978; Rawlings & Carter, 1977) have attempted to raise the awareness of lesbians regarding sexism and "heterosexism" (i.e., preference for opposite-sex relating), not only as they interact with an oppressive society, but as they come in contact with the therapeutic setting as well.

When the issue is raised of psychotherapeutic treatment for individuals having a homosexual orientation, at least two questions have been asked frequently by clinicians and researchers from varying theoretical and socio-sexual backgrounds: (a) Is fundamental change in sexual orientation possible? (Keener, 1986/1987) and (b) should

treatment be provided that focuses on bringing about such a change, even if requested?

Both theoretical perspectives on homosexuality and reports of poor success rates in therapy have been utilized to suggest that a homosexual orientation is a core personality characteristic and therefore unchangeable (Hampson, 1965; Harry, 1984; Newman, 1974; Poole, 1970; Smith, 1980). The individuals advocating this view have insisted that therapy should focus on dealing with clients' homophobic feelings (i.e., those that have been internalized and those of society) in order to minimize or eradicate conflicts surrounding their sexual identity. However, Keener's (1986/1987) overview of the literature demonstrated that psychotherapy has yielded change in the direction of heterosexuality for some clients, which calls into question the assumption of the immutability of homosexuality. In Freud's (1962) opinion, such changes in his patients following psychoanalysis and hypnosis refuted the claim that homosexuality is innate and immutable.

Sobocinski's (1990) statement has aptly summarized the current trend of thinking with regard to the second question:

A growing amount of research showing homosexuality per se to not be associated with any greater degree of pathology than is heterosexuality has led to changes in therapeutic focus from questions of "How can one alter the sexual preferences of gay and lesbian clients?" to . . . "How best can gay and lesbian clients be assisted in establishing a mature adult identity integrating their sexual and emotional preferences?" (p. 240)

Homosexuality: In need of treatment?

In spite of the fact that this shift in thinking mentioned by Sobocinski (1990) is gaining increasing acceptance, Jones and Workman (1989) commented that four years after the vote of the American Psychiatric Association to delete homosexuality from the DSM-III, "a survey found that 69% of psychiatrists believed that homosexuality 'usually represents a pathological adaptation'" (p. 214), and 60% felt that homosexuals were "less capable of mature loving relations than heterosexuals" (Lewes, 1988, p. 223). The literature reveals that there is a considerable number of psychologists and psychiatrists who to some degree continue to support this opinion.

Herron, Kinter, Sollinger, and Trubowitz (1988) claimed that in their clinical work they had "not found a 'happy homosexual'" (p. 396), and Siegel (1988) remarked about her clients' "volatility of their suffering" (p. xi). Moberly's conceptualization concurred with that of Beiber et al. (1962), that "homosexuality is not constitutional, but rather the outcome of pathologic parent-child relationships" (Moberly, 1983b, p. 44). She was quick to clarify her position, however, stating that the "problem is the disruption of the child's libidinal bond with the parent of the same sex" (p. 47), although such difficulties are not necessarily the product of intentional parental actions and/or neglect.

Thorpe, Katz, and Lewis (1961) asserted that "the consensus of both psychoanalytic and non-psychoanalytic clinical research is that homosexuality is an expression of abnormal personality development due to psychological factors" (p. 321). Gershman (1975) considered homosexuality, among other sexual disorders, as a deviation that is "observable in people who have failed to integrate their gender identity" (p. 305). Kaye (1975), in discussing Gershman's article, agreed that "homosexuality is not a healthy or even a variant of human sexuality and that the compulsive homosexual is in a chronically anxious state" (p. 314).

Further, the general public continues to regard the gay lifestyle in negative terms. Some opinion surveys, according to Knox (1991), "have indicated that at least three out of four Americans believe homosexual relations are wrong or immoral, implying that many believe homosexuality is a chosen lifestyle rather than a normal variant of sexual behavior" (p. 20). This type of information only confirms the belief of those in the homosexual community that society is homophobic.

However, an equally vocal group continues to attempt to dispel the view of homosexuality as maladaptive or as a sign of deficiency. Acosta (1975) contended that "an increasing number of investigators further argue that homosexuals are

not necessarily psychologically disturbed individuals" (p. 10). In his critique of Bieber et al., Churchill (1967) suggested that homosexuality is neither pathological nor rooted in conflicts and anxieties from early childhood, but a spontaneous and natural means of expressing sexuality. Similarly, Bell, Weinberg, and Hammersmith (1981) took issue with the focus placed on the parental constellation by advocates of psychoanalytic theory when they stated, "We find the role of parents in the development of their sons' sexual orientation to be grossly exaggerated" (p. 183).

Marmor (1973), among other writers, has suggested that pathology cannot be attributed merely because of etiology, countering the assumption that "if there is a disturbed parent-child relationship in the background of someone with variant sexual behavior this proves that the disturbed relationship is causally responsible and that the individual with such variant behavior must be mentally ill" (p. 1208). Although Marmor may have been attempting to demonstrate how ludicrous those conclusions seem, in his statement that "all personality idiosyncrasies" can be traced to various historical and developmental backgrounds, his justification trivializes the impact of past experiences with parental figures on the development of such crucial areas as gender identity and sexual orientation.

Some, by their emphasis on statistics regarding the incidence of homosexuality in the general population, have

attempted to normalize the existence of the homosexual orientation, reporting figures of up to 10%. Poole (1970) cited an incidence of 11-20% of females having had a homosexual experience, with 3-8% definitely of homosexual orientation; Sobocinski (1990) maintained that approximately 5-10% of the population is predominantly homosexual, although current estimates place the figure in the range of 2-3%. However, Moberly (1983b) again cautioned that "numbers alone do nothing to prove the normality of homosexuality. Although the incidence of homosexuality is undoubtedly considerable, it is a logical fallacy to assume that sheer numbers imply normative character" (p. 85).

Bell and Weinberg (1978) found that a large number of gay and lesbian individuals in their study had thought about changing their orientation at some point, but only a relatively small proportion had actively sought psychotherapeutic treatment. One-fourth of the homosexual males in their study seriously considered discontinuing their practices, with one-third to one-half of those making only one attempt; in contrast, although only one-fifth of lesbians considered discontinuing their homosexual behavior, a majority (80-85%) of those women made at least one serious attempt to do so. Escamilla-Mondanaro (1977) cited a study in which 91% of the 65 lesbians interviewed claimed they had never sought treatment to be cured of their homosexuality, but that 70% maintained a heterosexual front.

Clearly, the debate within the academic and research communities is far from concluded concerning whether individuals with a homosexual orientation, based on its etiology, would benefit from psychotherapeutic intervention were they to desire change. However, the fact that such individuals exist, for whom homosexual feelings are experienced as ego-dystonic to varying degrees, leaves clinicians faced with both ethical and practical considerations, as well as accusatory comments from the pro-gay community and its proponents.

Ethical considerations

Several authors (Davison, 1976; Silverstein, 1977; Sobocinski, 1990) have labeled therapists who offer services focusing on changing sexual orientation as "unethical." Silverstein (1977), who perceived the client's request for change of sexual orientation as asking "the therapist to play the role of the punishing sadist" (p. 207), queried further:

And what of the therapist who would agree to change sexual orientation? I suggest that such a therapist is just as confused about these issues as his prospective patient . . . about issues of masculinity and femininity, that he is very concerned about his own self-esteem, and that he would be just as depressed as his patient if he thought he were homosexual. (p. 209)

Davison (1976) claimed that it is "probable that the very existence of change-of-orientation programs strengthens societal prejudices against homosexuality and contributes to the self-hate and embarrassment that are determinants of the

'voluntary' desire by some homosexuals to become heterosexual" (p. 157). He also suggested that therapists should not offer services that help homosexuals change, a view supported by Silverstein (1977) and Sobocinski (1990).

Halleck (1976), in a slightly more balanced discussion of the client's request for therapy in order to change orientation, proposed the introduction of informed consent:

To the extent that we seek true voluntariness in our patients, our obligation is to provide our patients with a maximum amount of information. In an idealized clinical scenario, the homosexual who is considering the possibility of changing his behavior should have some information as to current biological and psychological theories of homosexuality and how they relate to him. He should have at least some idea as to the extent to which his current suffering or uneasiness is related to oppressive environmental stress, particularly that stress generated by a society's intolerance of homosexuality. He should know the possible hazards of any treatment he might undertake and should be aware of all the therapist's concerns as to the possible gains or losses for the patient if therapeutic intervention is successful. (p. 170)

Even Silverstein has conceded that homosexual clients, who have been given all pertinent information as outlined by Halleck, have the final choice. However, Davison (1976) urged the necessity to "first desensitize them to their guilt. Allow them to dissolve the shame about their desires and actions and to feel confident about their sexuality. After that, let them choose, but not before" (p. 160). Sobocinski (1990), in his discussion of vignettes depicting ethical dilemmas, more recently has applied a negative perspective, similar to that of Halleck's:

The therapist needs to emphasize to [the client] that there is no convincing evidence that long-term changes in sexual orientation through therapy actually work. Furthermore, efforts at changing a person's sexual orientation have been rejected as unethical in nature, reflecting the heterosexual biases and prejudices of this society. (p. 244)

Interestingly, in strong contrast to his own opinion against working to change the homosexual orientation, Sobocinski revealed that "a recent survey indicates that nearly half of the psychologists who responded felt that treating homosexuality per se as pathological constituted ethical practice" (p. 241). Marmor (1980) suggested that "if their motivation to change is sincere and strong, I believe they deserve an opportunity to try to accomplish their goal, with all the help that psychotherapy can give them" (p. 276).

Variables Influencing Treatment With Homosexuals

In spite of the many theories espoused regarding the etiology of the homosexual orientation, application of theories in the clinical setting has yielded inconsistent, if not poor, results (Acosta, 1975; Siegel, 1988). Although some interpret this to mean that fundamental change in the homosexually-oriented individual is rare, if not impossible, a critical factor in determining treatment outcome would logically be based on the degree to which application of sound theoretical conceptualizations in therapeutic interventions occurs. Researchers such as Bieber et al. (1962) and clinicians such as Herron, Kinter, Sollinger, and

Trubowitz et al. (1980) and Pattison and Pattison (1980) have discovered client characteristics that underlie good prognosis: (a) the client's desire to change, (b) some degree of respect for the same-sex parent, (c) therapy beginning prior to age 35, and (d) prior heterosexual experiences (e.g., dreams, fantasies, interactions).

However, it is clear that other important factors, such as the therapist and his or her background (i.e., personal, theoretical, sexual), have not been as widely discussed or investigated.

Therapist's gender. An aspect of treatment that has been raised pertains to the gender of the therapist and whether it should be the same as that of the client. Moberly (1983b), who viewed opposite-sex relationships as more-or-less irrelevant to the development of the homosexual orientation and considered the primary deficits as being in the realm of same-sex relationships, has advocated that "a therapist of the same anatomic sex as the homosexual . . . is required, if deficits in same-sex attachment (and the needs met through same-sex attachment) are to be met" (p. 74). This gender-specific therapy, referred to as a "controlled transference" (p. 74) in Moberly's terms, permits the development of an intense attachment through which the client's unmet emotional needs (e.g., for love, dependency, identity) can be addressed without the possible interference of "secondary eroticisation" (p. 75).

Apart from the resolution of these needs, Moberly (1983b) has asserted as well that the goal of heterosexual identity and relationships is impossible: "Heterosexuality [or heterosexual object-choice] implies that same-sex identificatory needs have been met, and consequently that relationships do not require to be governed by a reparative urge towards the fulfillment of one's own identity" (1983b, p. 37). Nicolosi (1991), in his 12 years of clinical work with male homosexuals, has observed similar deficits in gender identity and early development as those indicated by Moberly. Although Nicolosi has not conducted a formal empirical study, narrative reports of client interactions are the basis of his own explanation of reparative therapy. Nicolosi does not guarantee a cure which rids the individual of all homosexual feelings, but views the acquisition of gender identity as a potentially lifelong process for those who truly want to address areas of early deprivation.

Advocates for the lesbian population have been more vocal about their view of the need for a therapist of the same gender and, preferably, with similar ideologies (i.e., feminism) (Browning, 1987). Riddle and Sang (1978) have indicated that "because of the centrality of female socialization concerns to the problems experienced by lesbians, a therapist versed in feminist issues and feminist therapy would appear essential" (p. 96). Some concerns have been raised following research by Garfinkle and Morin (1978)

who discovered that male therapists have tended to equate masculinity with psychological health; also, in comparison with male therapists, female therapists did not hold as rigidly to traditional sex-role attitudes and were "less devaluing of stereotypically feminine characteristics in homosexual [male] clients" (p. 110).

Brooks (1981) addressed the gender issue in a study, based on subjects' questionnaires, that explored lesbians' assessment of their therapist and therapeutic experience in relation to the therapist's gender. Analysis of the data revealed a significant relationship between the perceived effectiveness of therapy and the therapist's sex, that is, lesbians viewed the outcome of treatment as more positive with a heterosexual female than with a heterosexual male therapist. Furthermore, lesbians evaluated their work with a lesbian therapist as more effective in comparison to that with a heterosexual male. Although Brooks found that similarity of the therapist's sex and sexual orientation to that of the client were of "considerable importance," she concluded that "a therapist's sex role ideology would seem to be considerably more relevant to the therapeutic relationship than his or her sex or sexual orientation" (p. 198).

Likewise, Lenihan's (1985) observations of support groups for gay clients showed that a majority of subjects expressed that their experience was positive and growth-

promoting regardless of the therapist's sex and sexual orientation. "In our experience the gender of the therapist is less important than freedom from bias and a healthy sex-role perspective" (Lenihan, 1985, p. 736). Siegel (1988) more recently cited studies that have refuted the protocol that women alone should conduct analysis with lesbians. Harvey (1987) asserted that "same-sex identification comes about through the felt approval of one's gender identity by both parents" (p.61), thereby implying that therapy can be effective with a clinician of either gender.

In spite of these contrasting views, Moberly's (1983b) gender-specific therapy (or controlled transference), based on her theoretical conceptualizations, seems to be a logical recommendation for clinical work with members of the homosexual population. Also, the literature more commonly supports the model of male therapists with gay men and female therapists with lesbians than mixed-gender relationships, and case studies suggest that clients have made therapeutic gains in such a clinical setting.

Johnson and Brock (1988), who utilized the term "gender-specific therapy" to describe their treatment with a range of clientele (i.e., not only homosexuals), realized that such therapy is not effective for all individuals and/or all presenting problems. Nevertheless, they found in their clinical experience that such a relationship was able to "explain more behavior in positive masculine and feminine

ways without divergence into denial and passiveness" (p. 58). However, proponents of these views have conducted few, if any, empirical studies to test their assertions and to determine whether the therapist's gender has an actual significant impact on the homosexual's progress in therapy.

In therapeutic settings where more methodical information-gathering has been implemented to assess client perceptions and satisfaction, the data have suggested that the therapist's gender is secondary in importance, if that (Lenihan, 1985). Siegel (1988) offered an explanation of why gender may not be as critical a factor for therapeutic efficacy as some have thought: "Analysands project in treatment the kind of object they need. . . . They appear to have little difficulty projecting paternal transferences onto a female analyst or maternal transferences onto a male analyst" (p. 204).

Therapist's sexual orientation. In spite of evidence suggesting that treatment outcome is not based primarily on the coincidence of the therapist's and client's sex, some have added to the gender factor an even greater emphasis on the therapist's sexual orientation. This is the result of the suspicion individuals of the homosexual community have for our homophobic society in general, and mental health professionals in particular. Not only do they feel that the psychological community promotes heterosexism and seeks to change homosexuals into heterosexuals (Riddle & Sang, 1978),

but they are not "overjoyed that any group of psychiatrists, social workers, and psychologists have decided by vote that homosexuality is not necessarily pathological behavior" (Escamilla-Mondanaro, 1977, p. 258). The resulting mistrust has been the impetus behind the development of increasing numbers of clinics and programs staffed by homosexuals with a focus on gay issues and the use of an "affirmative therapy" model (Enright & Parsons, 1976).

In fact, Rawlings and Carter (1977) claimed outright that "few 'straight therapists' are qualified" (p. 253) to conduct therapy with gay clients. Their greatest criticism of heterosexual therapists is their lack of practical knowledge regarding the homosexual culture. Sang (1977), among a number of other gay advocates, alleged that the training received by psychotherapists has not prepared them to work with clients having a homosexual orientation; the perceived result has been a view of homosexuals as individuals having personal "hang-ups" or being "sick" and in need of a cure. "Until professionals recognize that there is nothing in their training which facilitates their working with lesbians, and as long as this society discriminates against lesbians, lesbians should and will continue to distrust 'straight' mental health workers" (Escamilla-Mondanaro, 1977, p. 258).

Rawlings and Carter (1977) were even more emphatic about their expectations for therapists, speaking

particularly in their discussion of work with lesbians:

Mere acceptance or tolerance of alternative lifestyles is insufficient to qualify therapists to work with lesbians. Therapists need to be knowledgeable concerning the lesbian subculture, the societal pressures lesbians face and the political significance of lesbianism. (p. 253)

Escamilla-Mondanaro (1977) seemingly precluded the idea of heterosexual therapists working with lesbians: "Any therapist, raised and trained in this society, who is not a lesbian herself, is not equipped to work with lesbian clients in a therapeutic setting" (p. 258). Her reasoning is based on the assumption that homosexual clients' acceptance of their orientation and feelings is ameliorated by contact with a positive role model. Riddle and Sang (1978) assumed that a female therapist with a homosexual orientation, through personal example, would be able to validate the lifestyle and deal with issues of sexism, in order to provide a sense of female identity. Rawlings and Carter (1977) have suggested that "the lesbian therapist has the added advantage of serving as a role model to counteract negative self-images internalized by most lesbians" (p. 253).

In his recent theoretical discussion of ethical treatment with gay adolescents, Sobocinski (1990) has offered his explanation of why an adolescent, without access to a positive role model of this type, may experience homosexual feelings as ego-dystonic: "For the adolescent, the 'self' is located 'out there' in the context of shared

interpersonal mutuality, so that any conflict between various interpersonal contexts is experienced as a conflict of the self with itself" (p. 244). Therefore, because the potential for, and reality of, such interpersonal and intrapersonal conflict exists for gay adolescents among their typical high school peers (Price, 1982), Sobocinski further warned that:

A lack of appropriate adult role models for gay and lesbian youth, an excessive focus on the sexual aspect of their identity, the absence of opportunities to explore sexuality within an appropriate social context, and feelings of guilt and fears may delay or even prevent gay and lesbian adolescents from achieving a healthy identity incorporating their affective and sexual orientation. (p. 240)

Rochlin (1982) cited research which showed that the perception of similarity between the counselee and counselor is positively correlated with the sense of empathy and unconditional positive regard experienced in the therapeutic setting. As an advocate for client-therapist similarity with gay and lesbian clients, Rochlin further stated that "the perpetuation of that pain [i.e., of difference and alienation even in the family of origin] in therapy with a non-gay therapist is one of the commonly reported reasons for gay and lesbian clients' dissatisfaction or failure in traditional psychotherapy" (p. 23). However, Rochlin cautioned against the assumption that a therapist, by virtue of his or her sexual orientation, is the most effective clinician with gay and lesbian clients: "Being homosexual does not guarantee freedom from homophobic and heterosexist

bias. . . . A homophobic or heterosexist therapist, regardless of sexual orientation, cannot be helpful to lesbian and gay clients" (p. 24).

In contrast, the study by Brooks (1981) did not reveal a significant difference on the measure of clients' perception of treatment outcome when comparing heterosexual female with lesbian therapists. Likewise, Lenihan (1985) indicated that heterosexual therapists can display attitudes conducive to the personal and emotional growth of homosexual clients.

Moberly (1983b), on the basis of her theoretical position, cautioned against therapists who are themselves homosexual working with individuals with a homosexual orientation: "The similarity of his own psychological needs might prove to be more of a limitation in some cases than in others" (p. 75). Moberly recognized that even in the context of gender-specific therapy, the controlled transference relationship eventually would elicit the negative feelings associated with same-sex ambivalence and intense dependency needs. However, she conceived that the frustrations inherent in a "natural transference" (referring to the typical homosexual relationship), that is, inability to have same-sex love needs met by a partner who has similar needs, which leads to disillusionment and subsequent detachment, would be obviated by clinical work with a heterosexual therapist.

This principle of pairing a homosexual client with a heterosexual therapist of the same gender has the potential to provide greater relational stability. But, as Moberly (1983b) has stated, "This is not to assert that a homosexual therapist could not help a fellow-homosexual. Indeed, he would have the advantage of understanding the condition from within" (p. 75). In a similar vein as the advocates for gay therapist-client relationship, Moberly also suggested that heterosexual therapists require additional preparation, both academically and emotionally, if they will presume to offer effective treatment to those requesting change in their sexual orientation.

Until heterosexual therapists are prepared to provide controlled single-sex relationships, the only kind of therapeutic relationship available to the homosexual will be the natural transference of an ordinary homosexual relationship, where, as it happens, emotional needs tend to be acted out sexually. (Moberly, 1983b, p. 75)

Non-specific therapist variables. The discussion of the treatment with homosexuals has focused considerable attention on the therapist's gender and sexual orientation, with some acknowledgment of political ideology (i.e., feminism) in work with lesbians. In spite of this emphasis, some empirical evidence suggests that a client's perception of positive therapy outcome may be related to less immediately identifiable factors, such as personality characteristics and capacity for empathy. Lenihan (1985) concluded that in group therapy with homosexuals, it was

more crucial for therapists to be proficient in facilitating group process, in addition to being comfortable with their own lifestyle and sexuality and having an awareness of potential negative biases pertaining to homosexuality. "The critical factors, then, are not sexual orientation, lifestyle or gender of the therapist but professional effectiveness and the quality of therapeutic relationships established in the group" (Lenihan, 1985, p. 736).

This observation only serves to support Rogers' (1980) view that the therapeutic relationship must include the crucial factors of "creative, active, sensitive, accurate, empathic, nonjudgmental listening" (p. 14). Further, a therapist who demonstrates genuineness, "unconditional positive regard" (p. 116) and empathic understanding is more likely to observe an increasingly greater insight, self-acceptance and congruence in the client. Marmor (1980) indicated that a therapist's acceptance of, and non-critical attitude toward, the homosexual client provides the opportunity to "increase the patient's self-esteem and self assertiveness" (p. 278). Sanders (1980) agreed that an essential factor in treatment with individuals looking to change their sexual orientation is the therapist's non-judgmental perspective which allows clients to set their own goals for therapy.

It is obvious that these therapist characteristics and attitudes are no less important in work with homosexual

individuals than with any other clientele, whether the clinician is male or female, heterosexual or homosexual, or has strong religious convictions about this issue or not. However, those who have decried therapists offering services directed at changing an individual's sexual orientation give the impression that such work implies the use of coercion, guilt and shame to bring about change. Silverstein (1977) is of this opinion:

Any form of therapy that encourages guilt or reinforces low self-esteem is a therapy whose meta-message defines a sado-masochistic relationship. Further, therapeutic goals that are directed toward the punishing of humiliating behavior and fantasies are the acting out of the sado-masochistic relationship. (p. 207)

He added that "as long as the therapeutic procedure is defined by attitudes of guilt and punishment, therapy will be a failure" (p. 208).

Sang (1977) seemed to suggest that clinicians, based on their own agenda and homophobia, impose change in orientation as the focus of treatment: "Therapists who believe that their function is to change homosexuals into heterosexuals deprive the individual of choosing what is best for herself" (p. 272). She appeared to dismiss any consideration that, by their own deliberate decision and resolve, clients may seek this goal of treatment as a means to work through the conflict they experience between their homosexual identity and moral values. However, this is not to suggest that all individuals seeking change have this level of motivation; in fact, some homosexuals initially

enter therapy more with the purpose of changing their sexual orientation in acquiescence to societal pressures.

Ironically, some writers with views similar to those of Sang (1977) and Silverstein (1977) have presented therapeutic goals that seem equally emphatic about promoting the homosexual lifestyle, rather than exploring developmental issues that might underlie its evolution. Their approach has been couched in terms of eradicating the oppressive internalized homophobia, upon which they assume the client's wish to change his or her sexual orientation is based. Margolies, Becker, and Jackson-Brewer (1987), in fact, stated: "We consider the opposite of an intrapsychic homophobia to be a feeling that one's homosexuality is ego-syntonic and integrated into one's whole life" (p. 230). The conspicuous absence of any acknowledgment of, or provision for, those who seriously want to progress from homosexuality toward a heterosexual identity simply is suggestive of another form of therapist bias.

This bias is particularly noticeable in the comments of Sophie (1987), who stated that "The goal of treatment, then, is not the achievement of any particular identity, but the reduction in internalized homophobia which enables the woman to accept her own lesbian desires and experiences and choose her own identity" (p. 54). Similarly, Browning (1987) indicated:

The therapeutic task . . . becomes one of helping the client avoid (identity) foreclosure . . . by validating

the woman's right to her identity as a lesbian and an adult and encouraging her to examine all of her parents' values and expectations, not just related to sexual orientation. (p. 48)

These comments, while they appear to support a client's realistic consideration of both heterosexual and homosexual identities, encourage clients to accept their homosexual desires apart from an understanding of the context in which such feelings and behaviors developed and are now expressed. Payne (1981) pointed out that therapists would not advocate sexual contact and/or genital intimacy as a heterosexual woman's method for developing her identity. She therefore suggested that it is inconsistent that "this intimacy should be the remedy openly touted by the various homosexual apologists and even by many psychologists and doctors as normal and 'natural'" (p. 34).

The responsibilities of psychotherapists in this area, then, are to propose general treatment goals, explore the clients' overall emotional development, which includes the factors contributing to sexual identity formation, and leave the choice of sexual orientation to the client. In the opinion of Margolies, Becker, and Jackson-Brewer (1987), "it is the therapist's role to facilitate the differentiation between the pathological uses of these defense strategies [i.e., denial, projection, identification with the aggressor, often observed as part of internalized homophobia] and the healthy functions" (p. 235). Masters and Johnson (1979) stated that "if treatment of homosexual

dissatisfaction is to be effective, therapists must attempt and attain a reasonable degree of professional neutrality in conducting treatment programs, and the client must demonstrate sincere levels of motivation for altering their sexual orientation" (p. 392).

Religious values. The role of religious teachings and moral values has come under no greater scrutiny than in the discussion of sexuality, and particularly with regard to the development of the homosexual identity. Poole (1970) and Marmor (1980) found that negative attitudes toward sexuality in general, often equated with strict moral standards and labeled puritanical, contribute to an avoidance of heterosexual intimacy and an attraction to those of the same gender. Poole (1970) inferred that "Western cultures such as ours tend to produce lesbians because of the rigid traditional concept of the abomination and sinfulness of heterosexual activity" (p. 55). However, these assertions appear to be based on either informal interviews or a small sample of homosexual individuals, and do not recognize the multiple factors that lead to the development of a homosexual orientation.

Bell and Weinberg (1978) investigated the role of religion in the lives of approximately 700 homosexual males and females. They claimed that "organized religion is largely responsible both for the heterosexual majority's aversion to homosexuality and for feelings of alienation

among large numbers of homosexuals" (Bell & Weinberg, 1978, p. 149). According to their research, and that of Saghir and Robins (1973), many homosexual adults reject organized religion because of the increased sense of guilt, markedly diminished sense of self-esteem, and extreme alienation they experience in some religious circles.

In fact, Bell and Weinberg discovered that half of their Caucasian homosexual male subjects and a majority of white female subjects (between 50% and 80%) fell in the category designated "not religious at all," in contrast to less than one-third of black homosexual males and one-fourth of black lesbians who claimed no religious affiliation. One-fourth or fewer of the white homosexual subjects considered themselves moderately or very religious, whereas more than one-third of both black homosexual males and females categorized themselves as such. Twice as many black homosexual males than white males attended church at least a few times per month, and it was many of the white homosexual males who expressed that their homosexuality actually had weakened their feelings toward religious matters.

These findings suggest that a majority of the homosexual community is not involved in any religion, that black homosexuals are more religiously affiliated than their white counterparts (which is consistent with the comparison of the wider black vs. white subcultures), and that a majority (66% in Bell and Weinberg's study) of the

respondents view homosexuality as having little impact on their religiousness. The study, however, did not assess directly the subjects' level of religious commitment prior to their involvement in the homosexual lifestyle in order to determine whether their commitment may have been greater in the past or whether, and to what extent, their affiliation had been influenced by the reaction of others. Therefore, no definitive statement can be made as to the effect of religion on a homosexual individual's involvement.

From the experiences of their subjects, Bell and Weinberg (1978) noted that some churches are more sensitive than others to the difficulties experienced by homosexual individuals. They based this on the view that "the motivations and ethics involved in any sexual activity are far more important than the nature of the activity itself and that all human beings, regardless of sexual orientation, are responsible for what they intend in what they do" (p. 150). Although this statement seems reasonable in its consideration of motive as more crucial than behavior, it is nevertheless in sharp contrast to traditional religious values based on the authority of the Bible, which has been traditionally understood to view sexual attitudes and thoughts, behavior (i.e., any extra-marital sexual activity, including homosexual contact) and motive equally, and all as evidences of the fallen nature. Jones (1989) challenged, "To live out the call of the gospel properly, we must

faithfully regard as sin all that God himself condemns" (p. 29).

The historical overview has revealed that these same Bible passages continue to be the focus of considerable debate as to the accuracy of interpretation. Theologians who interpret those Scriptures with less traditional and conservative views have placed greater emphasis on the historical and cultural contexts in which they were written, where homosexuality was part of pagan ritual practice that included prostitution. As a result, these individuals have called into question the applicability of these Bible passages and their interpretations to current attitudes toward, and practices of, homosexuality. However, a more complete theological discussion of this debate is beyond the scope of this paper.

Instead of minimizing the impact of, or justifying, homosexual activity in light of personal intent and ethics, some have attempted to incorporate religious teachings as an essential part of the process of change in behavior, as well as in desires and motives. Stafford (1989) cited a number of individuals, leaders of the ex-gay movement, who have relied heavily on personal and religious values to work toward change in their own lives and, through teaching, support and example, now offer hope to others. These men and women, through their focus on developing "spiritual

understanding of themselves . . . in relationship to God" (p. 21), see the process as a means of replacing distorted patterns of thought and interaction with new perspectives for relating.

This venture, however, is not without its pitfalls and failures. Cook (1989) attested to his own struggles and repeated relapses back into the homosexual lifestyle, even with some of those for whom he was providing guidance and offering hope of lasting change in orientation. This admission only confirms how intractable homosexuality, as well as any other evidence of the human sin nature, can be. Cook's comments serve to emphasize the need for greater support, mercy, and patience on the part of Christians for those struggling with homosexuality. Jones (1989) has challenged the church to become a partner in providing healing and support for those involved in ex-gay ministries by embodying the Bible's view of God's mercy and love for all sinners.

Therapeutic modality. In clinical work with ego-dystonic homosexuals, various theories have been used as the basis for treatment. Psychoanalysis and psychodynamic psychotherapy have been the most commonly used modalities and reportedly have yielded limited success in bringing about lasting change in sexual orientation (Acosta, 1975; Smith, 1980). Other treatment methods have incorporated behavioral techniques, such as classical conditioning,

systematic desensitization and aversive therapy, with an equally poor record of lasting change (Keener, 1986/1987; Neill, 1987/ 1988; Anderson-Barnes, 1990/1991).

Keener's (1986/1987) review of the literature revealed that fundamental change has occurred for some, but primarily among those who are younger than age 35, who are strongly motivated, and who have had some prior heterosexual experience. Smith (1985) pointed out that the common goals of most treatment methods have been "to promote heterosexual adjustment and to diminish or extinguish homosexual thoughts, feelings and behaviors" (p. 402). However, change in these areas is not equivalent to a major shift in an individual's core sexual identity. Keener (1986/1987) and Anderson-Barnes (1990/1991) theorized that psychotherapy was effective only to the degree that the client was motivated to change without demands from the therapist to do so. The primary criticism is that much of the research has neither determined what is an accurate measure of prior involvement in the homosexual lifestyle before treatment nor what is the degree of change in orientation resulting from therapy, except as based on the clinician's judgment.

Group therapies often have been utilized subsequent to, if not simultaneous with, individual psychotherapy, but with more numerous reports of success in bringing about change in homosexual orientation than any other single modality. A major criticism has been that assessment of change has been

based on subjective data, such as client self-report or therapist judgment. The type of group (e.g., heterogeneous, homogeneous, self-help) has not been a crucial factor in bringing about change, but rather, case reports have suggested that success is more apt to occur when the therapeutic goal (i.e., change in sexual orientation) is clearly delineated. Client motivation has been determined to be the most essential factor, regardless of the time at which the decision to change is made (i.e., prior to or during treatment), although the group's mutual understanding and acceptance coupled with confrontation and modeling would be among the advantages for those struggling to change their sexual orientation. Keener (1986/1987) concluded, "It would appear that anyone who chooses to change can do so to some degree with the help of group therapy" (p. 36).

The use of behavioral techniques also has generated considerable criticism, not only for the lack of reliable measures to assess change, but for the fact that change is focused on behavior and arousal, and not on core identity. Keener (1986/1987) discovered evidence that "aversion therapy," in spite of its effectiveness in decreasing homosexual behavior, "focuses on training the client to avoid homosexual thoughts and behavior but offers no help toward becoming heterosexual" (p. 25). In contrast, employment of classical conditioning provided increased responsiveness to heterosexual stimuli, with little

influence in decreasing homosexual reactivity. Therefore, combined use of aversive therapy and classical conditioning has been proposed as effective treatment for decreasing homosexual behavior and arousal and increasing heterosexual arousal. However, the lack of both follow-up studies to determine the duration of change and use of more objective measures to assess change will continue to draw criticism about the effectiveness of behavioral techniques in bringing about lasting, fundamental change.

As explained by Keener (1986/1987) and Neill (1987/1988), the mixed support within the psychological community as to the effectiveness of treatment has been due, in part, to the lack of empirically-derived data based on reliable quantitative measures that assess the level of change attained during treatment. Smith (1985) has raised the question regarding aspects of homosexuality by which to determine change, whether behavior, attraction, identity or some combination of these. The introduction of the Klein Grid has provided a much needed tool for assessing the multi-dimensional nature of an individual's homosexual orientation, in place of the broad categorization offered by the Kinsey Scale's heterosexual-homosexual continuum. The KSOG has become a means for identifying particular aspects of homosexuality in which, and the extent to which, change may have occurred during the course of treatment.

In the years since Keener's (1986/1987) review, few studies have been conducted that focus on treatment for ego-dystonic homosexuals who have chosen to change their homosexual orientation. However, Anderson-Barnes (1990/1991) utilized the KSOG to assess the effectiveness of Christian group treatment for those seeking to change. Thirty-nine of the 75 males and females enrolled in four groups at that time agreed to participate in the study, with an understanding of the weight placed on religious teachings in the process of change. Thirty-two subjects, in three non-residential groups, met for 3 hours over 20 weeks during a 9 month period. Each meeting was comprised of worship, a didactic session on sexuality and wholeness, healing prayer, and small group interaction. The format was similar to that used by Pattison and Pattison (1980). The purpose was to help members develop non-erotic relationships with individuals of the same sex. The treatment for the seven subjects in a residential program was based on the same principles and didactic materials, although interactions with, and support from, both group leaders and other members were more immediately available by virtue of their living situation. Five individuals on a waiting list constituted the control group.

At the beginning of the 20 week program (named Living Waters), all of the subjects were asked to rate themselves on the KSOG as to their functioning in each of the areas in

the Past (prior to 6 months before this evaluation) and Present (within 6 months), as well as what they viewed as their Ideal. Only 13 of the 32 individuals in the non-residential groups completed the posttest questionnaires. Of the 19 who did not, 6 had moved from the area before completing the program, 5 dropped out at some point during the 9 month period, and 8 did not return the posttest questionnaires even though they completed the program. All 7 residential program participants completed the treatment and the questionnaires. Anderson-Barnes (1990/1991) hypothesized that the KSOG scores would decline in the course of the treatment program, which was interpreted as movement away from homosexuality toward a heterosexual orientation. In light of the emphasis on religious teaching, she also utilized the Allport Intrinsic-Extrinsic Religious Orientation Scale to determine the role of religion in change, anticipating an increase in subjects' intrinsic religiosity and decrease in extrinsic religiosity.

Anderson-Barnes' (1990/1991) data revealed that the KSOG scores declined in the dependent variables of self-identification, interpersonal sexual orientation, and intrapersonal sexual orientation following participation in the program, with the greatest change occurring for those who were enrolled in the program for the first time. Individuals who had attended the Living Waters program once or twice previously demonstrated a plateau effect in the

area of self-identification between the pre- and post-test conditions. However, with regard to both interpersonal and intrapersonal sexual orientation, those with prior Living Waters experience actually demonstrated a slight shift in a homosexual direction from pre- to post-test, although they rated themselves as more heterosexual than in the past.

High intrinsic religiosity was not predictive of greater degree of success in changing an individual's sexual orientation, although it was correlated with completion of the program. However, those who earned scores in the Low Intrinsic range consistently rated themselves as more heterosexual than those who fell in the High Intrinsic category. One explanation for this finding may be that High Intrinsic individuals have a greater commitment to moral/Biblical standards and higher personal expectations than their Low Intrinsic counterparts. As a result, they likely attempt to live in a manner more consistent with their moral beliefs and are acutely aware of the internal struggle with homosexual feelings, thereby rating themselves more strictly as to their progress.

In her discussion of the results, Anderson-Barnes admitted that the number of subjects whose results could be utilized for analysis (i.e., those who completed both pre- and post-test questionnaires) was greatly diminished by the rate of attrition. It is quite possible that some of those who chose not to complete the post-test questionnaires may

have felt that their self-evaluations would reveal little or no change in sexual orientation. Anderson-Barnes also addressed the results of individuals who were participating in Living Waters for their second or third time. She hypothesized that the plateau effect observed on the inter- and intra-personal sexual orientation measures suggested that the nature and rate of their change were qualitatively different in comparison with those of first-time program participants, whose motivation for, and hope of, change are at their highest during the initial months of treatment.

It also is possible that individuals who have been in the program at least once have developed greater expectations for progress in changing their orientation, yet experience increasing personal and interpersonal frustration as they continue to struggle with similar thoughts and feelings to those for which they initially sought treatment. As a result, some of the program's goals, particularly with regard to abstaining from homosexual contact while attempting to learn how to develop non-erotic friendships with members of the same sex, actually create a temptation for members to relapse into homosexual behaviors. This situation might arise if the latter goal is undertaken too soon in the therapeutic process, before adequate insight into the emotional needs that seem to underlie homosexual feelings has been attained and safe relationships have been developed to provide support.

Unfortunately, because the magnitude of the task of changing an individual's sexual orientation is great and the intensity of intimacy needs rarely diminishes, it is not surprising that members (and leaders) of ex-gay groups fall back into old patterns.

Other factors that must be considered in Anderson-Barnes' (1990/1991) interpretation of the results are the age of members at the time of participation in the program and the population from which the subjects were drawn. As has been indicated, Bell and Weinberg (1978) and Saghir and Robins (1973), whose subjects represented a wide sample of homosexuals, demonstrated that individuals are more amenable to change prior to age 35. No information was provided by Anderson-Barnes' to indicate the ages of group participants, although the demographics regarding educational backgrounds would suggest the subjects ranged in age from 20 to 35. Also, because the study participants were a small, self-selected number, they may not be representative of many homosexual individuals in the Christian community from which most of the group members are drawn. Gershman (1975) pointed out that even those who seek treatment are qualitatively different than those who do not seek help, assuming that those in the latter group are satisfied with the quality of their lives and are functioning adequately in emotional and relational areas.

In spite of these criticisms, the information regarding the Living Waters program provides a much needed, systematic evaluation of the effectiveness of Christian treatment groups that continue to arise from within the ex-gay movement. The data also allow closer examination of the gradual process of change in the various dimensions of sexual orientation. However, as Anderson-Barnes (1990/1991) has indicated, follow-up studies are needed to assess the type, extent, and durability of change that is accomplished through participation in such programs. This treatment modality warrants further investigation in order to determine aspects of the program that contribute to lasting change in sexual orientation, particularly where its use of spiritual/Biblical principles is concerned. These foundational concepts have become an integral part of programs such as Homosexuals Anonymous (Cook, 1989) and Courage (Harvey, 1987), which stress self-acceptance as well as self-restraint with a goal of celibacy.

Prevention

Considering the variable, and often poor, rates of reported success in changing sexual orientation through most treatment modalities, some psychotherapists and researchers have suggested the use of preventative measures that lessen the likelihood that a homosexual identity would develop (Acosta, 1975; Neill, 1987/1988). Moberly (1983b) advocated that "Prevention is more vital" than the process of healing

sought through therapy. Caprio (1954), in his exploration of female homosexuality, pointed to the role of parental figures in the venture:

Parents must assume a sense of responsibility in seeing to it that their children receive adequate sex education and that the home atmosphere is a healthy and congenial one. . . . When daughters receive security of affection from their mothers, they will be less likely to seek it later in life with substitute mothers. (pp. 286-287)

For those who have proposed early intervention, the primary focus of treatment has been suggested not only for the child and the same-sex parent, but for the whole family system. Marmor (1980) indicated that such therapeutic work would need to explore "aspects of family relationships that are hindering the development of satisfactory identification with the same-sex parent, [and promote] an affectionate and unambivalent relationship with the parent of the opposite sex and healthy peer associations" (p. 274).

Three studies, based on the principles mentioned above, have been conducted with boys displaying effeminate characteristics early in life, in order to determine the effectiveness of prevention strategies that focus on helping the child to develop a wider repertoire of masculine behaviors and greater comfort with his male identity. Newman (1976) discovered that any intervention must include the cooperation and active participation of parents, who often either fail to recognize the progressive nature and consequences of their son's gender disturbance or rationalize and ignore such behaviors in hopes that they

will diminish as the child matures. He found that boys who meet the diagnostic criteria for gender disturbance prior to puberty are at high risk for developing some form of gender identity disorder in adulthood.

Newman's (1976) treatment plan included a combination of individual psychoanalytic play therapy (1-2 times per week with a male therapist) and use of behavioral techniques, as well as individual and/or group counseling with parents. The therapeutic work, which spanned 4 years with 5 boys, resulted in the subjects' increased self-acceptance as a boy, an increase in both masculine and aggressive behaviors, at the same time that fememine behaviors declined. However, Newman based his assertion that patterns of gender orientation are not crystallized by age 3, as a majority of theorists contend, on his finding that his subjects were most responsive to treatment between the ages of 5 and 12. In follow-up interviews during adolescence, none of the boys reported any cross-dressing subsequent to treatment. Because the subjects in this study were few in number and not a random sample, the results likely are not representative of the personal and family situations surrounding the typical feminine boy.

In conjunction with his research with feminine boys, Green (1974, 1987) also provided treatment for subjects and their parents, which provided individual therapy for the child and each parent, group therapy for the boy, separate

groups for mothers and fathers, and finally some parent training. The premise for teaching parents was to train them "To act as therapists by instructing them on specific aspects of behavior which should be systematically encourage^d or discouraged at home" (Green, 1974, p. 246), with the use of such interventions as behavior programs.

The participants were given the opportunity to develop male identification within the unstructured group play and obtained additional exposure to an adult male role model in the process. The role of parental involvement and motivation was found to be crucial for treatment success, especially when the father-son relationship was strengthened through increased interpersonal contact and insight into the child's emotional needs.

Following his 15 year longitudinal, prospective study, Green (1987) appeared more pessimistic in his view of treatment effectiveness. Of the 12 subjects who participated in his therapy program, 9 indicated that they were either bisexual or homosexual in adolescence. In contrast to Newman (1976), Green attributed the "apparent powerlessness of treatment to interrupt the progression from 'feminine' boy to homosexual or bisexual man" (p. 318) as evidence that the child is most susceptible to deficits in the father-son relationship during the first few years, "beyond which the deficit cannot be remedied" (p. 319). Although his research did not demonstrate that early

intervention is effective in bringing about change, Green and his subjects viewed treatment as favorable, even if only to help minimize the possibility of social stigma and childhood conflict.

Discussion and Conclusions

According to DSM-III, ego-dystonic homosexuality was considered a psychosexual disorder based on the fact that some individuals, who previously experienced persistent and unwanted feelings of homosexual arousal and attraction, at some point want to develop the ability to sustain intimate relationships with the opposite sex. Among them are those who ultimately seek to establish a satisfying heterosexual marriage, to have children and to phase out homosexual impulses and thoughts as much as possible (Stafford, 1989). However, those who have attempted to make this transition have met with much discouragement or outright opposition from those who view homosexuality as a valid sexual orientation that requires no change.

The study of homosexuality has engendered considerable dialogue and controversy as to its etiology, with recent studies attempting to determine factors that might indicate a genetic and/or hormonal basis. The results have provided evidence to suggest that some individuals are biologically predisposed to experience feelings or exhibit behaviors consistent with a homosexual orientation. Developmental, familial, and societal factors appear to contribute to the

emergence of homosexuality as well, although theorists and researchers have yet to supply conclusive data to indicate which of these factors, and to what degree, they impact the formation of one's sexual identity. No clear data has been found to distinguish male from female homosexuality biologically, since much of the research continues to focus on homosexual males. Although social, psychoanalytic, and object-relations theories continue to emphasize the crucial nature of parental relationships, primarily with the parent of the same gender, very few well-constructed studies have been conducted to support such assertions.

The views as to the need for, and types of, therapeutic intervention have been as varied as theories of etiology. The primary area of debate has been whether individuals of a homosexual orientation need to seek psychological treatment. In spite of the American Psychiatric Association's removal of ego-dystonic homosexuality from the DSM-III-R as a specific psychosexual disorder, clinicians continue to be divided in their view of the need for intervention. A substantial number of psychologists consider homosexuality as evidence of a developmental deficit, largely thought to be based on some early disruption in relationships with parental figures, and as such, in need of reparation through a corrective emotional experience. In contrast, many others have suggested that the offer of treatment in order to change one's homosexual orientation is unethical because, in

their opinion, as a valid biological variation of sexuality, it cannot and should not be altered.

A second area of disagreement has concerned the focus of treatment if a client does present complaints of ego-dystonic feelings. For those holding to the theory that homosexuality is symptomatic of a deficit (e.g., relational, emotional) that precluded the development of the most common gender identity (i.e., heterosexuality), treatment has focused on exploring childhood memories and working through issues that led to a detachment from the same-sex parent and their sexual identity. Behavioral techniques have been employed to minimize, or extinguish, homosexual behaviors and feelings that are experienced as unwanted.

However, proponents of homosexuality who view it as a valid lifestyle have stated clearly that treatment must attempt to decrease, and deal with the effects of, the individual's internalized homophobia. In effect, their goal is the acceptance of the individual's homosexual feelings so that they become ego-syntonic. In their view, counseling that focuses on change actually perpetuates homophobia, both societal and internal, by inferring that homosexuality is deviant or the evidence of a developmental delay. Therefore, treatment, if even permissible, is required only to the degree that it helps individuals accept and integrate their homosexual feelings as a consistent part of their

sexual identity in the face of societal pressures that promote heterosexuality.

Advocates for the gay community have become quite dogmatic about their demands for the therapeutic environment, specifying that the therapist must be homosexual in order for empathy and integration of feelings to occur. This attitude is particularly strong among lesbians, who indicate that only lesbian therapists with feminist ideologies are capable of understanding their subculture's unique needs in an oppressive society. The issue has not been studied in a systematic or objective manner and, therefore, the literature does not support this supposition. Rather, the data suggests that clients would benefit most in work with skilled clinicians whose non-judgmental and non-directive attitudes allow clients to explore all experiences and feelings that might relate to the emergence of their homosexuality without fear of censure.

In spite of increased acceptance of homosexuality in clinical and societal opinion, some professionals continue to see the need to offer treatment for those who experience their feelings as ego-dystonic and, at minimum, want to see them diminish in intensity. Regardless of the treatment modality, however, the process of change from homosexuality to heterosexuality is gradual, difficult, often subject to relapse, and, as a result, has been viewed as an almost

futile effort. Importantly, a review of the literature suggests that the individual's desire to change is of primary importance, although treatment that begins prior to age 35 which instills hope and maintains motivation seems to add to the possibility for success. Previous heterosexual contact seems to provide a foundation for further development of relationships with the opposite sex, but a degree of respect for the same-sex parent is a crucial, yet frequently unmentioned, factor. With these characteristics as a foundation, a treatment plan that incorporates individual and group psychotherapies appears to have the ability to offer some relief for those who desire change.

Not only does this clinical work address the emotional needs formerly left unmet by the relationship with the same-sex parent, but it gives clients the opportunity to develop an awareness of their sexuality and ways in which they have used it to express, and attempt to fulfill, unmet needs. Group therapies, in particular, balance off individual work that focuses on insight with specific information about sex roles with members of the same- and opposite-sexes, as well as modeling of heterosexual interactions where requested and appropriate. The common element among these therapeutic relationships is the availability and development of non-erotic relationships with members of the same sex.

Much of the literature that examines treatment with homosexuals does not address the individual's moral nature,

although religious values and those who espouse them consistently come under attack as encouraging homophobia. As Margolies, Becker, and Jackson-Brewer (1987) indicated, internalized homophobia is a defense mechanism, typifying the ego's struggle between rules and desires that pertain to homosexuality. But the question arises as to what must be diminished in order to bring about psychological health: the rules or the desires. A traditional moral view would propose that individuals change their desires in the direction of conformity with conservatively-interpreted biblical tenets, whereas advocates for the homosexual lifestyle suggest that an individual's desires and identity are valid in and of themselves, regardless of how disparate they are from societal norms and/or moral rules.

Other views do exist between these two polar opinions, largely due to the debate around conflicting interpretations of Scripture passages such as Romans 1:27, which states, "Men abandoned the natural function of the woman and burned in their desire towards one another, men with men committing indecent acts and receiving in their own persons the due penalty of their error." The point at which individuals holding these various perspectives may agree is that a "primary treatment goal is to reconcile the conflicting pulls between sexual impulses and shame and guilt [in such a way that the ego learns] to gratify the id without recriminations from the super-ego" (Margolies, Becker, &

Jackson-Brewer, 1987, p. 236), although they strongly differ in what they see as the most beneficial and/or morally correct outcome of intervention with homosexual individuals.

What seems to have occurred within the psychological community in the discussion of homosexuality, however, has been a diminution of the importance of the superego and moral standards. For some clients struggling to change their homosexual orientation, the adherence to moral (if not biblical) standards and their incorporation in decision-making are crucial for a sense of personal well-being. These individuals find it essential to make decisions that are in congruence with their deeply-held values, even if the choice is difficult to maintain and carry out consistently. Treatment must provide the means by which individual's standards and desires are explored and discussed with a non-judgmental, consistent perspective, yet without promoting guilt, neurotic or otherwise. At the same time, ethical standards for psychological treatment indicate that these rules cannot, nor should not, be imposed on those who have no such interest to change their orientation. The greatest outcry from the gay community has been toward those who insist that they comply with moral and social standards to which they as homosexuals feel no obligation of allegiance. Ultimately, the choice remains the client's as to the direction and outcome of treatment. For the ego-dystonic homosexual, this choice demands a high price, for the

process of change is painstaking and replete with temptations that might elicit feelings and behaviors once thought to be conquered. The spiritual component of treatment and recovery cannot be taken lightly. The leaders of ex-gay ministries would suggest that consistent participation in, and commitment to, a religiously-based group provides a unique and supernatural source of support, hope and motivation that has yet to be studied.

As Moberly stated, "If healing is desirable, prevention is even more vital" (p. 78). The most effective use of resources (i.e., people, time, emotional energy) would appear to be in prevention of gender disturbance, particularly when symptoms are visible and become problematic in childhood (Acosta, 1975; Neill, 1987/1988; Smith, 1980). Although Green's (1987) work did not provide encouraging data to indicate that treatment minimizes or averts development of homosexuality, he likely would agree with Newman (1976), who suggested that two inseparable goals of treatment with feminine boys must be to facilitate "a happier childhood as well as primary prevention of an adult gender identity disorder" (p. 687).

The same offer of a happier, more satisfying life should be granted adults in the homosexual community as well. Those who view their identity with pride and feel they are functioning adequately in relationships likely will never seek therapy for change, and should not be forced to

do so. Yet the individual struggling with ego-dystonic feelings on a daily basis should be offered emotional relief in the form they choose, without fear of reprisal from the gay community, or coercion from therapists, clergy, or society in general.

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